Calendar No. 220

99TH CONGRESS *1st Session*	SENATE	REPORT 99-101

VETERANS' ADMINISTRATION HEALTH-CARE PROGRAMS IMPROVEMENT ACT OF 1985

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

TO ACCOMPANY

S. 876

JULY 8, 1985.—Ordered to be printed

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JULY 8, 1985.—Ordered to be printed

Mr. MURKOWSKI, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 876]

The Committee on Veterans' Affairs, to which was referred the bill (S. 876) to amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health-care programs, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute, and recommends that the bill, as amended, do pass.

COMMITTEE AMENDMENTS

The amendments are as follows:

Strike out all after the enacting clause as follows:

That (a) this Act may be cited as the "Veterans' Administration Health Care Programs Improvement Act of 1985".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

ALTERNATIVE TO NURSING HOME CARE; PILOT PROGRAM

SEC. 2. (a) Section 620 is amended by adding at the end thereof the following new subsection:

"(g)(1) The Administrator shall establish and conduct a pilot program in five geographic areas to furnish medical, rehabilitative, and social services, which would obviate the need for nursing home care, to veterans who would otherwise be eligible for nursing home care pursuant to this section and who wish to participate in the program. The Administrator may—

"(A) contract for such services from non-Veterans' Administration public and private providers, where economical and high quality services and re-

sources are available as alternatives or adjuncts to care furnished by the Veterans' Administration; or

["(B) where neither of these options is feasible, develop direct Veterans' Administration health related and supportive services designed to obviate the veteran's need for nursing home care furnished by the Veterans' Administration.

["(2) A veteran is eligible to receive services under the pilot program if the Administrator determines that—

["(A) the veteran is eligible to receive nursing home care under subsections (a) through (d) of this section;

["(B) without receiving the services furnished under paragraph (1) of this subsection, the veteran would otherwise receive nursing home care; and

["(C) as a result of receiving the services furnished under paragraph (1) of this subsection and any additional services available to the veteran in the veteran's community, the veteran would be able to reside at home in a substantially self-sufficient manner.

In administering the program, the Administrator shall give priority to veterans over sixty-five years of age and to veterans who are catastrophically disabled.

["(3) Each Veterans' Administration medical facility administering the pilot program in each of the five designated geographic areas shall furnish unified case management services for each veteran receiving services under the pilot program in each geographic area, including services furnished under a contract. For purpose of this paragraph, case management is defined as the coordination of all services furnished, including, but not limited to, outreach, screening, assessment of needs, planning, referral, provision for or arrangement of services, monitoring, reassessment, and followup.

["(4) The cost of carrying out the pilot program in any fiscal year, excluding the cost of carrying out paragraphs (5) and (6) of this subsection, may not exceed 60 percent of the cost that would have been incurred by the Veterans' Administration during such fiscal year, if the veterans receiving services under the pilot program had been furnished, instead, nursing home care under subsections (a) through (d) of this section.

["(5) The Administrator shall conduct a study of the program to determine—

["(A) the feasibility, medical advantages and cost-effectiveness of services as provided in this subsection as an alternative for nursing home care;

["(B) the extent to which such a program can—

["(i) improve the quality of care that such veterans receive under this section compared to the care they would otherwise receive;

["(ii) allow such veterans to receive more appropriate kinds of care under this section than they would otherwise receive;

["(iii) reduce nursing home admission rates;

["(iv) reduce the number of days that veterans to whom this section applies are hospitalized;

["(v) reduce mortality rates among such veterans; and

["(vi) reduce the cost of long-term care for eligible veterans under this section; and

["(C) the comparative advantages and disadvantages of furnishing such care through facilities that are not under the direct jurisdiction of the Administrator, and through facilities that are under the direct jurisdiction of the Administrator.

["(6)(A) Not later than eighteen months after the commencement of the pilot program required by paragraph (1) of this subsection, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the findings of the study made pursuant to paragraph (5) of this subsection. The findings of the study shall be based on the results of the first twelve months of the program. The report shall include a description of the administration of the program (including a description of the veterans receiving services under the pilot program and of the services furnished to the veterans under the pilot program), the Administrator's interim evaluation of and findings on the program (including the matters referred to in paragraph (5) of this subsection), and any recommendations for administrative or legislative action that the Administrator considers appropriate, based on the results of such program.

["(B) Not later than ninety days after the termination of the pilot program, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a final report on the program. The report shall include the results of the study conducted under paragraph (5) of this subsection, which shall be based on the administration, evaluation and findings of the program for the entire period of the program.

[''(7) The pilot program shall commence January 1, 1986, and shall terminate December 31, 1988.''.

[(b) The table of sections at the beginning of chapter 17 is amended by striking out the item relating to section 620 and inserting in lieu thereof the following:

[''620. Transfers for nursing home care; adult day health care; alternative to nursing home care; pilot program.''.

[TREATMENT AND REHABILITATION FOR ALCOHOL OR DRUG DEPENDENCE DISABILITIES

[SEC. 3. (a)(1) Section 620A(a)(1) is amended—

[(A) by striking out ''pilot'' in the first sentence; and

[(B) by striking out the second sentence.

[(2) Section 620A is further amended by striking out subsections (e) and (f) and inserting in lieu thereof the following:

[''(e) The Administrator shall monitor the performance of programs operated by each contract facility furnishing care and services under this section to determine—

[''(1) with respect to the programs, the medical advantages and cost effectiveness that result from furnishing care and services in contract facilities, rather then in Veterans' Administration facilities;

[''(2) with respect to contract facilities—

[''(A) the level of success of each contract facility under the program, considering—

[''(i) the rate of successful rehabilitation for veterans who have received the contract facilities' care and services under the program for disabilities referred to in subsection (a) of this section;

[''(ii) the rate of readmission to each contract facility program by such veterans (with respect to such disabilities);

[''(iii) whether the treatment and services furnished by contract facilities obviated the need of such veterans for hospitalization for such disabilities;

[''(iv) the ability of the program to aid in the transition of such veterans back into their communities;

[''(v) the average duration of the treatment that such veterans have received from the contract facility under the program; and

[''(vi) any other factors the Administrator considers appropriate;

[''(B) the total cost for the care and services furnished by each contract facility;

[''(C) the average cost for each veteran receiving care and services furnished by contract facilities; and

[''(D) the appropriateness of such costs, by comparison to—

[''(i) the charges for the same care and services furnished generally by other halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities in the same geographic area; and

[''(ii) the historical costs for such services for the period of time that this program was a pilot program, taking into account economic inflation.

[''(f) The Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the administration of this section, including, but not limited to, a description of the care and services provided; the matters referred to in subsection (e) of this section, and the Administrator's findings, evaluation, and recommendations on the program.''.

[(3) Subsection (g) of such section is amended—

[(A) by striking out ''(g) The'' and inserting in lieu thereof ''(g)(1) Subject to paragraph (2) of this subsection, the''; and

[(B) by adding at the end thereof the following new paragraph:

[''(2) The Administrator may not enter into contracts under this section which would exceed a total program level of $10,000,000 in any fiscal year.''.

[(b) The table of sections at the beginning of chapter 17 is amended by striking out ''; pilot program.'' and inserting in lieu thereof a period for the item relating to section 620A.

[COMMUNITY RESIDENTIAL CARE PILOT PROGRAM FOR CHRONICALLY MENTALLY ILL VETERANS

[SEC. 4. (a) Section 630 is amended—

[(1) in subsection (b)(1), by striking out ''subsection (a) of''; and

[(2) by adding at the end thereof the following new subsection:

["(g)(1) The Administrator shall establish and conduct a pilot program in five geographic areas under which the Administrator may contract for care to be furnished in community residential care facilities to eligible veterans suffering from chronic mental illness and who wish to participate in the program. Notwithstanding subsection (b)(3) of this section, the Administrator shall pay to each facility the charges for such care. The Administrator shall prescribe regulations to carry out this subsection, as authorized by, and in accordance with, subsection (d) of this section. In each geographic area, such program shall also involve the use of Veterans' Administration psychiatric day treatment and hospital-based home care programs.

["(2) A veteran is eligible to receive care under the pilot program if the Administrator determines that—

["(A) the veteran is suffering from chronic mental illness and is eligible to receive care under section 610,

["(B) without receiving the care furnished by a community residential care facility under paragraph (1) of this subsection, the veteran would otherwise receive hospital or nursing home care in a Veterans' Administration facility, and

["(C) by receiving the care furnished by a community residential care facility under paragraph (1) of this subsection and any additional services available to the veteran in the veteran's community, the veteran eventually would be able to reside at home in a substantially self sufficient manner.

["(3) Each Veterans' Administration medical facility administering the pilot program in each of the five designated geographic areas shall furnish unified case management services for each veteran receiving care under the pilot program, including care furnished under a contract. For purposes of this paragraph, case management is defined as the coordination of all services furnished, including, but not limited to, outreach, screening, assessment of needs, planning, referral, provision for or arrangement of services, monitoring, reassessment, and followup.

["(4)(A) Not later than eighteen months after the commencement of the pilot program, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the pilot program. The report shall include a description of the administration of the pilot program during the first twelve months of the pilot program, a description of the geographic areas where the pilot program is being carried out, the costs of the pilot program, and the Administrator's findings and evaluations with respect to (1) the quality of care furnished under the pilot program to eligible veterans, and (2) the effectiveness of the pilot program in maintaining such veterans in their communities and in obviating the need for readmission to Veterans' Administration medical facilities.

["(B) Not later than ninety days after the termination of the pilot program, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a final report on the pilot program. The report shall include the Administrator's findings on the effectiveness of the pilot program (relating to the matters referred to in the second sentence of subparagraph (A) of this paragraph) and any recommendations for administrative or legislative action that the Administrator considers appropriate based on the results of such program.

["(5) The pilot program shall commence January 1, 1986, and shall terminate December 31, 1988.".

[(b) The table of sections at the beginning of chapter 17 is amended by striking out the item relating to section 630 and inserting in lieu thereof the following:

["630. Community residential care; community residential care pilot program for chronically mentally ill veterans.".

[QUALITY ASSURANCE

[SEC. 5. (a) Chapter 73 is amended by adding at the end thereof the following new subchapter:

["Subchapter V—Quality Assurance

["§ 4151. Responsibilities

["(a) The Administrator shall—

["(1) establish and conduct a comprehensive quality assurance program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery to eligible veterans;

["(2) delineate the responsibilities of the Office of the Inspector General of the Veterans' Administration and the Department of Medicine and Surgery with respect to the monitoring, evaluation and conduct of the Veterans' Admin-

istration quality assurance program conducted by the Department of Medicine and Surgery;

["(3) allocate—

["(A) sufficient resources, and personnel with skills and qualifications necessary to review a medical quality assurance program, to enable the Office of the Inspector General to monitor the quality assurance program conducted by the Department of Medicine and Surgery, and

["(B) sufficient travel funds to enable the Department of Medicine and Surgery to carry out its quality assurance responsibilities and to enable the Inspector General to monitor the quality assurance program conducted by the Department of Medicine and Surgery.

["(b) The Administrator shall, as part of the comprehensive quality assurance program established and conducted pursuant to subsection (a)(1) of this section, require the Chief Medical Director of the Department of Medicine and Surgery—

["(1) to establish mortality and morbidity rate norms to be used as standards for all surgery programs conducted by the Department of Medicine and Surgery;

["(2) to collect data on mortality and morbidity rates for each surgery program including, but not limited to, each cardiac surgery program conducted by the Department of Medicine and Surgery, and information pertaining to and an analysis of—

["(A) characteristics of the patient population,

["(B) the level of risk involved, based on the age of the patient, the kind of illness, and the severity of the illness, and

["(C) any other factors that the Chief Medical Director considers appropriate;

["(3) to compare such data to the established standards and to evaluate such data to determine whether there are any significant deviations from the standards that would indicate deficiencies in the quality of care; and

["(4) to make any recommendations based on the comparison made in paragraph (3) of this subsection.

["§ 4152. Report

["At the beginning of each fiscal year, the Inspector General of the Veterans' Administration shall review the mortality and morbidity data collected pursuant to paragraph (2) of subsection (b) of section 4151 to determine whether the mortality and morbidity statistics are within the range of the appropriate mortality and morbidity standards established pursuant to paragraph (1) of subsection (b) of section 4151, and shall submit a report to Congress on his findings.".

[(b) The table of sections at the beginning of chapter 73 is amended by adding at the end thereof the following:

["SUBCHAPTER V—QUALITY ASSURANCE

["4151. Responsibilities.
["4152. Report.".

[ADVISORY COMMITTEE ON VETERANS' ADMINISTRATION FACILITY PLANNING

[SEC. 6. (a) Subchapter II of chapter 3 is amended by adding at the end thereof the following new section:

["§ 223. Committee on Veterans' Administration Facility Planning

["(a) The Administrator shall establish an advisory committee to be known as the Advisory Committee on Veterans' Administration Facility Planning (hereinafter in this section referred to as 'the Committee').

["(b)(1)(A) The Committee shall consist of members appointed by the Administrator from the general public, including—

["(i) representatives of veterans; and

["(ii) individuals who are recognized authorities in fields pertinent to health care policy and planning, clinical practice, and medical facility construction.

["(B) The Committee shall include, as ex officio members——

["(i) the Secretary of Defense (or a representative of the Secretary of Defense designated by the Secretary);

["(ii) the Secretary of Health and Human Services (or a representative of the Secretary of Health and Human Services designated by the Secretary); and

["(iii) the Chief Medical Director (or the Director's designees).

["(c)(1) The Committee shall review the criteria for sizing Veterans' Administration medical facilities. The review shall include—

[“(A)(i) an evaluation of veterans' access to the Veterans' Administration health care system;

[“(ii) an evaluation of the Veterans' Administration criteria for sizing Veterans' Administration medical facilities and the method for determining such criteria; and

[“(iii) any recommendations relating to modifications in the criteria and processes.

[“(d)(1) Not later than October 1 of each year, the Committee shall transmit to the Administration a report setting out the findings of the Committee during the preceding fiscal year and such recommendations for administrative and legislative action as the Committee considers appropriate.

[“(2) Not later than six months after the date the annual report of the Committee is transmitted to the Administrator, the Administrator shall transmit the annual report, together with such comments on the report and such recommendations for legislation as the Administrator considers appropriate, to the Committees on Veterans' Affairs of the Senate and the House of Representatives.

[“(e) The Administrator shall determine the number, terms of service, pay and allowances of members of the Committee appointed by the Administrator, and of members of the staff of the Committee, if any.

[(b) The table of sections at the beginning of chapter 3 is amended by inserting after the item relating to section 222 the following new item:

[“223. Advisory Committee on Veterans' Administration Facility Planning.”.

[EFFECTIVE DATE

[SEC. 7. The amendment made by section 3 of this Act shall take effect October 1, 1985.]

and insert in lieu thereof the following:

That (a) this Act may be cited as the “Veterans' Administration Health-Care Programs Improvement Act of 1985”.

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal, is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—PILOT PROGRAMS

PILOT PROGRAM OF VIETNAM VETERAN RESOURCE CENTERS

SEC. 101. Section 612A is amended by adding at the end the following new subsection:

“(h)(1) In order to evaluate the effectiveness, feasibility, and desirability of providing veterans eligible for readjustment counseling under this section with additional services described in paragraph (2) of this subsection, through facilities furnishing such counseling, the Administrator, during the period beginning January 1, 1986, and ending December 31, 1988, shall conduct a pilot program to provide and coordinate the provision of such additional services.

“(2) The additional services referred to in paragraph (1) of this subsection that shall be provided and coordinated under such pilot program are—

“(A) counseling with respect to and assistance in applying for all benefits and services under laws administered by the Veterans' Administration for which veterans participating in the pilot program may be eligible;

“(B) employment counseling, training, placement, and related services described in sections 2003 and 2003A of this title or provided under any other laws administered by the Secretary of Labor;

“(C) initial intake and referral services with respect to alcohol or drug dependence or abuse disabilities and followup services for veterans who have received treatment for such dependence or abuse disabilities; and

“(D) coordination assistance for veterans participating in the pilot program with respect to such veterans' receipt of (i) services provided under the pilot program, and (ii) other benefits and services provided under laws administered by the Veterans' Administration, the Secretary of Labor, or any other Federal agency or official.

“(3)(A) In order to carry out the pilot program under this subsection, the Administrator shall—

"(i) designate as demonstration projects ten facilities which, on the date of the enactment of this section are providing readjustment counseling (which projects shall be referred to as Vietnam Veteran Resource Centers (hereinafter in this subsection referred to as 'Centers')),

"(ii) provide such additional staff and other resources as are necessary to enable such Centers to provide the services referred to in paragraph (2) (A), (C), and (D) of this subsection, and

"(iii) notify the Secretary of Labor of the need for the assignment, pursuant to subparagraph (B)(ii) of this paragraph, of personnel to provide the services described in paragraph (2)(B) of this subsection at such Centers.

"(B)(i) The Administrator shall be responsible for coordinating the assignment and use of employees, on full- or part-time bases, as appropriate, in each Center and, shall in carrying out that responsibility, make maximum feasible use of the Veterans' Administration employees who are providing services at each facility on the date it is designated as a Center under this subsection.

"(ii) The Secretary of Labor shall provide for the assignment to each Center, on full- or part-time bases, as appropriate, of disabled veterans' outreach specialists appointed pursuant to section 2003A of this title or employees on the staffs of local employment service offices who are assigned to perform services pursuant to section 2004 of this title.

"(4)(A) In order to ensure appropriate guidance, coordination, implementation, and assessment of the pilot program under this subsection, the Administrator shall establish, and provide appropriate staffing and other resources for, a Vietnam Veteran Resource Center Coordinating Committee (hereinafter in this subsection referred to as the 'Committee').

"(B) The Committee shall be composed of—

"(i) a member or members appointed by and representing the Administrator;

"(ii) a member or members appointed by and representing the Chief Medical Director;

"(iii) a member or members appointed by and representing the Chief Benefits Director; and

(iv) a member appointed by and representing the Assistant Secretary of Labor for Veterans' Employment.

"(C) Not less frequently than every 6 months, the Committee shall report to the Administrator, the Chief Medical Director, the Chief Benefits Director, and the Assistant Secretary of Labor for Veterans' Employment on the implementation and status of the pilot program. The first such report shall be submitted not later than June 30, 1986.

"(5) After the Committee is established pursuant to paragraph (4) of this subsection, the Administrator may delegate to the Chief Medical Director the responsibility for carrying out the pilot program.

"(6)(A) Not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience under the pilot program during its first 15 months of operation. The report shall include—

"(i) the Administrator's assessment of—

"(I) the effectiveness of the pilot program in providing and coordinating the provision of the services described in paragraph (2) of this subsection and counseling and services furnished under subsections (a) and (b) of this section; and

"(II) the cost-effectiveness of the program;

"(ii) a description of any administrative actions that the Administrator plans to take generally to increase the coordination of the provision of such services to eligible veterans and to other veterans;

"(iii) any recommendations for legislation, relating to the provision of such services to eligible veterans and to other veterans, that the Administrator considers appropriate; and

"(iv) a comparison of such assessment, plans, and recommendations with the evaluation of and the recommendations relating to the readjustment counseling program included in the report required by subsection (g)(2) of this section.

"(B) Not later than April 1, 1989, the Administrator shall submit to such Committees a final report on the program. The report shall include updates of all information provided in the report submitted pursuant to subparagraph (A) of this paragraph, the Administrator's final assessment of the pilot program based on 36 months of operation, and any recommendation for administrative or legislative action that the Administrator considers appropriate to include in the report.".

PILOT PROGRAM OF COMMUNITY-BASED PSYCHIATRIC RESIDENTIAL TREATMENT FOR CHRONICALLY MENTALLY ILL VETERANS

SEC. 102. (a) Subchapter II of chapter 17 is amended by adding at the end the following new section:

"§ 620B. Community-based psychiatric residential treatment for chronically mentally ill veterans; pilot program

"(a)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may, during the period beginning January 1, 1986, and ending December 31, 1989, conduct a pilot program under which the Administrator may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities (hereinafter in the section referred to as 'contract facilities') for eligible veterans suffering from chronic mental illness disabilities. Such pilot program shall be planned, designed, and conducted by the Chief Medical Director, with the approval of the Administrator, so as to demonstrate (A) any medical advantages and cost-effectiveness that may result from furnishing such care and services to veterans with such disabilities in such contract facilities rather than in inpatient facilities over which the Administrator has direct jurisdiction, and (B) the potential, as a result of the furnishing of such care and services, for enabling such veterans to live in settings other than inpatient facilities.

"(2) Before furnishing such care and services to any veteran through a contract facility, the Administrator shall approve (in accordance with criteria which the Administrator shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which such veteran is to be furnished such care and services.

"(b) In the case of each eligible veteran provided care and services under this section, the Administrator shall designate a Veterans' Administration employee to provide case management services.

"(c) Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a contract facility under this section. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the contract facility. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Veterans' Administration facility that provided the assistance.

"(d) For the purposes of this section—

"(1) The term 'eligible veteran' means a veteran who at the time of referral to a contract facility—

"(i) is being furnished hospital, domiciliary, or nursing home care from the Veterans' Administration for a service-connected chronic mental illness disability, or

"(ii) is being furnished such care from the Veterans' Administration for a chronic mental illness disability and is a veteran described in section 612(f)(2) of this title.

"(2) The term 'case management' includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration), monitoring, reassessment, and followup.

"(e)(1) Not later than February 1, 1989, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the experience under the pilot program during the first 36 months of the program. The report shall include the Administrator's interim evaluation and findings regarding—

"(A) the quality of care furnished to participating veterans through contract facilities;

"(B) the effectiveness of the pilot program in enabling the participating veterans to live outside of Veterans' Administration inpatient facilities and to achieve independence in living and functioning in their communities; and

"(C) the effect of the pilot program on the average daily census in the Veterans' Administration hospitals, nursing homes, and domiciliary facilities participating in the program (taking into account whether the beds previously occupied by the participating veterans were subsequently occupied by other eligible veterans or remained unoccupied).

"(2) Not later than April 1, 1990, the Administrator shall submit to such Committees a final report on the pilot program. The report shall include updates of all information provided in the interim report submitted pursuant to paragraph (1) of this subsection, the Administrator's final evaluation, findings, and conclusions regarding the program based on 48 months of operation, and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in such report.".

(b) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620A the following new item:

"620B. Community-based psychiatric residential treatment for chronically mentally ill veterans; pilot program.".

PILOT PROGRAM OF NONINSTITUTIONAL ALTERNATIVES TO INSTITUTIONAL CARE

SEC. 103. (a) Subchapter II of chapter 17 is further amended by adding at the end the following new section:

"§ 620C. Noninstitutional alternatives to institutional care; pilot programs

"(a)(1) In order to evaluate the effectiveness, feasibility, and desirability of various actions that would obviate the need for furnishing hospital, nursing home, or domiciliary care to veterans eligible under this chapter for and otherwise in need of such care, the Administrator, during the period beginning January 1, 1986, and ending December 31, 1989, and subject to subsection (c) of this section, shall conduct a pilot program under which such veterans will be furnished at ten demonstration project sites medical, rehabilitative, and health-related services in noninstitutional settings. Not less than five of such projects shall involve the use of a geriatric evaluation unit at a Veterans' Administration health-care facility.

"(2) In selecting veterans for participation in the program, the Administrator shall accord priority to veterans who have service-connected disabilities, to veterans who are 65 years of age or older, and to veterans who are totally and permanently disabled.

"(b)(1)(A) In order to avoid duplication of services available from the Veterans' Administration and other sources to veterans participating in the pilot program and to avoid fragmentation of effort under the program, the Administrator shall in the conduct of the program (i) furnish appropriate health-related services solely through contracts with appropriate public and private agencies that provide such services, and (ii) in the case of each veteran furnished services under the program, appoint a Veterans' Administration employee to furnish case management services.

"(B) For the purposes of subparagraph (A) of this paragraph, 'case management' includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration), monitoring, reassessment, and followup.

"(2) In order further to avoid such duplication and fragmentation and in order to evaluate the cost-effectiveness of utilizing certain health services of agencies other than the Veterans' Administration in cases in which no Veterans' Administration facility in the vicinity of a demonstration project provides such services, the Administrator, in not more than two of the projects, may utilize appropriate health services of appropriate public and private agencies that furnish such services.

"(3) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a facility furnishing services to veterans under paragraph (1)(A) of this subsection. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the facility concerned. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equip-

ment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds alloted to the Veterans' Administration facility that provided the assistance.

"(c)(1) The total cost of conducting the pilot program under this section shall not exceed 60 percent of the cost that would have been incurred by the Veterans' Administration during the period of the pilot program if the veterans being furnished services under the pilot program had been furnished, instead, nursing home care under section 610 of this title. In any one fiscal year, the cost of carrying out the pilot program shall not exceed 65 percent of the cost that would have been so incurred for such year under such section 610.

"(2) Expenditures for services furnished to veterans under the pilot program shall be made from appropriated funds that would otherwise have been expended to provide intermediate hospital care to eligible veterans.

"(d)(1) The Administrator shall conduct a study of the pilot program to determine with respect to the participating veterans--

"(A) the feasibility, medical advantages, and cost-effectiveness of the services furnished under the program as an alternative to hospital, nursing home, or domiciliary care; and

"(B) the extent to which such a program can—

"(i) furnish such veterans with more appropriate kinds and levels of care than they would otherwise receive;

"(ii) reduce hospital, nursing home, or domiciliary facility admission rates for such veterans;

"(iii) reduce the number of days that such veterans are institutionalized;

"(iv) reduce mortality rates among such veterans; and

"(v) reduce the cost of long-term care for such veterans under this chapter.

"(2) Not later than February 1, 1989, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the study required by paragraph (1) of this subsection setting forth the Administrator's findings based on the results of the study of the program's first 36 months experience. The report shall include a description of the administration of the program (including a description of the veterans furnished services and of the services furnished under the pilot program), the Administrator's interim evaluation of and findings on the program (including the matters referred to in paragraph (1) of this subsection), and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

"(3) Not later than April 1, 1990, the Administrator shall submit to such Committees a final report on the study required by paragrpah (1) of this subsection. The report shall include updates of all information provided in the interim report submitted pursuant to paragraph (2) of this subsection, the Administrator's final evaluation, findings, and conclusions regarding the program based on 48 months of operation (in the context of an assessment, which the report shall contain, of the needs of older eligible veterans for noninstitutional health and health-related services and of the availability of such services from non-Veterans' Administration sources), and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.".

(b) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620B (as added by section 9(b) of the Act) the following new item:

"620C. Noninstitutional alternatives to institutional care; pilot program.".

CHIROPRACTIC SERVICES PILOT PROGRAM

SEC. 104. (a)(1) Subchapter III of chapter 17 is amended by adding at the end the following new section:

"§ 630A. Chiropractic services; pilot program

"(a) The Administrator, subject to the provisions of this section, shall conduct a pilot program consisting of not less than one demonstration project in each of five geographic regions of the United States during the period beginning January 1, 1986, and ending December 31, 1988—

"(1) to furnish certain chiropractic services to veterans eligible for medical services under this chapter; and

"(2) to evalute the therapeutic benefits and the cost-effectiveness of furnishing such chiropractic services to such veterans.

In developing the pilot program, the Administrator shall consult with the Secretary of Defense regarding the demonstration project carried out by the Secretary under section 632(b) of the Department of Defense Authorization Act, 1985 (10 U.S.C. 1092 note).

"(b)(1) The Administrator shall, subject to subsection (c) of this section and under regulations which the Administrator shall prescribe, reimburse a veteran eligible for medical services under this chapter for the reasonable charge for chiropractic services furnished to the veteran under the demonstration projects carried out under subsection (a) of this section, for which such veteran has made payment, if—

"(A) such chiropractic services were for the treatment of a service-connected neuromusculoskeletal condition of the spine,

"(B) the veteran is a veteran who has been furnished hospital care by the Veterans' Administration for a neuromusculoskeletal condition of the spine within a 12-month period prior to the furnishing of such chiropratic services, or

"(C) the veteran is a veteran described in section 612(f)(2) of this title who has been furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine,

to the extent that such veteran is not entitled to such chiropractic services or reimbursement for the expenses of such services under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.

"(2) The Administrator may, in lieu of reimbursing a veteran for a reasonable charge for chiropractic services under paragraph (1) of this subsection, make payment of the reasonable charge for such chiropractic services directly to the chiropractor who furnished such services.

"(c)(1) The Administrator shall, in consultation with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, establish a schedule of reasonable charges for chiropractic services furnished under the demonstration projects carried out under subsection (a) of this section. Such schedule shall be consistent with the reasonable charges allowed under section 1842 of the Social Security Act (42 U.S.C. 1395u).

"(2) The amount payable by the Administrator for chiropractic services furnished under such demonstration projects shall not exceed $600 in any 12-month period in the case of any veteran.

"(d)(1) Notwithstanding any other provision of this title, total expenditures for chiropractic services reimbursed under this section shall not exceed $2,000,000 in any fiscal year.

"(2) Expenditures for such services shall be made from appropriations that would otherwise have been expended for travel and incidental expenses under section 111 of this title.

"(e) Not later than April 1 of each of the years 1987, 1988, and 1989, the Administrator shall prepare and submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the pilot program carried out under this section during the preceding fiscal year. Each such report shall include for such fiscal year—

"(1) the number of requests made by eligible veterans for reimbursement or payment for chiropractic services under this section and the number of such veterans who made such requests;

"(2) the number of such reimbursements or payments made and the number of veterans to or for whom such reimbursements or payments were made; and

"(3) the total amount of the expenditures for such reimbursements and payments.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 630 the following new item:

"630A. Chiropractic services; pilot program.".

(b) Section 601 is amended by adding at the end the following new paragraph:

"(9) The term 'chiropractic services' means the manual manipulation of the spine performed by a chiropractor (who is licensed as such by the State in which he or she performs such services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))) to correct a subluxation of the spine. For the purposes of this paragraph, such term does not include physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded.".

TITLE II—EXTENSIONS OF AUTHORITIES AND ELIGIBILITIES

DEFINITION OF VIETNAM ERA

SEC. 201. (a) Section 101(29) is amended to read as follows:

"(29) The term 'Vietnam era' means (A) the period beginning on August 5, 1964, and ending on May 7, 1975, and (B) the period beginning on February 21, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period.".

(b) The amendment made by subsection (a) shall take effect on October 1, 1985.

EXTENSION OF INTERIM HEALTH-CARE ELIGIBILITY BASED ON EXPOSURE TO DIOXIN OR OTHER TOXIC SUBSTANCES IN VIETNAM OR TO NUCLEAR RADIATION

SEC. 202. Paragraph (3) of subsection (e) of section 610 is amended to read as follows:

"(3) Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(5) of this section after September 30, 1989.".

COUNSELING FOR FORMER PRISONERS OF WAR

SEC. 203. (a)(1) Subchapter II of chapter 17 is further amended by adding after section 612A the following new section:

"§ 612B. Eligibility for counseling for former prisoners of war

"The Administrator may establish a program under which, upon the request of a veteran who is a former prisoner of war, the Administrator may, within the limits of Veterans' Administration facilities, furnish counseling to such veteran to assist such veteran in overcoming the psychological effects of such veteran's detention or internment as a prisoner of war.".

(2) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 612A, the following:

"612B. Eligibility for counseling for former prisoners of war.".

(b) The amendments made by subsection (a) shall take effect on October 1, 1985.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION

SEC. 204. (a) Section 620A is amended—

(1) in subsection (a)(1), by striking out "pilot" both places it appears;

(2) in subsection (e)—

(A) by striking out "fifth" and inserting in lieu thereof "eighth"; and

(B) by striking out "pilot";

(3) by amending subsection (f) to read as follows:

"(f)(1) The Administrator shall monitor the performance of each contract facility furnishing care and services under the program carried out under subsection (a) of this section to determine—

"(A) with respect to the program, the medical advantages and cost-effectiveness that result from furnishing such care and services;

"(B) with respect to the contract facilities generally—

"(i) the level of success under the program, considering—

"(I) the rate of successful rehabilitation for veterans furnished care and services under the program;

"(II) the rate of readmission to contract facilities under the program or to Veterans' Administration health-care facilities by such veterans with respect to disabilities referred to in subsection (a) of this section;

"(III) whether the care and services furnished under the program obviated the need of such veterans for hospitalization for such disabilities;

"(IV) the average duration of the care and services furnished such veterans under the program;

"(V) the ability of the program to aid in the transition of such veterans back into their communities; and

"(VI) any other factors that the Administrator considers appropriate;

"(ii) the total cost for the care and services furnished by each contract facility under the program;

"(iii) the average cost per veteran for the care and services furnished under the program; and

"(iv) the appropriateness of such costs, by comparison to—

"(I) the average charges for the same types of care and services furnished generally by other comparable halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities; and

"(II) the historical costs for such care and services for the period of time that the program carried out under subsection (a) of this section was a pilot program, taking into account economic inflation.

"(2) Not later than February 1, 1988, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience under the program during the preceding 4 fiscal years, including, but not limited to (A) a description of the care and services furnished, (B) the matters referred to in paragraph (1) of this subsection, and (C) the Administrator's findings, assessment, and recommendations regarding the program conducted under this section."; and

(4) by amending the catchline to read as follows:

"§ 620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities".

(b) The item relating to such section in the table of sections at the beginning of chapter 17 is amended to read as follows:

"620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities.".

TITLE III—HEALTH-CARE MANAGEMENT

VETERANS' ADMINISTRATION GRADE REDUCTION

SEC. 301. (a) Section 210(b) is amended by adding at the end the following new paragraph:

"(3)(A)(i) The Administrator may not in fiscal year 1986 or any subsequent fiscal year implement a grade reduction described in division (ii) of this subparagraph unless the Administrator first submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report containing a detailed plan for such reduction and a detailed justification for the plan, including a determination by the Administrator, together with data supporting such determination, that, in the personnel area concerned, the Veterans' Administration has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to the number of such employees at the salary levels involved who perform comparable functions in other departments and agencies of the Federal Government and in non-Federal entities. Any such report shall be submitted not later than the beginning of a period of 90 calendar days (not including any day on which either House of Congress is not in session) prior to the implementation of any proposed grade reduction.

"(ii) A grade reduction referred to in division (i) of this subparagraph is a systematic reduction, for the purpose of reducing the average salary cost for Veterans' Administration employees described in division (iii) of this subparagraph, in the number of such Veterans' Administration employees at any specific grade level.

"(iii) The employees referred to in division (ii) of this subparagraph include—

"(I) health-care personnel who are determined by the Administrator to be providing either direct patient-care services or services incident to direct patient-care services; and

"(II) individuals who meet the definition of professional employee as set forth in section 7103(a)(15) of title 5 and are employed in the capacity of engineers or attorneys.

"(B) Not later than the forty-fifth day after the Administrator submits a report pursuant to subparagraph (A) of this paragraph, the Comptroller General of the United States shall submit to such Committees on Veterans' Affairs a report on the Administrator's compliance with such subparagraph and shall include in the report the Comptroller General's opinion as to the accuracy of the Administrator's determination (and of the data supporting such determination) made pursuant to such subparagraph.

"(C) In the case of Veterans' Administration employees not described in division (iii) of subparagraph (A) of this paragraph, the Administrator may not in any fiscal year implement a systematic reduction for the purpose of reducing the average salary cost for such Veterans' Administration employees that will result in a reduction in the number of such Veterans' Administration employees at any specific grade level at a rate greater than the rate of the reductions systematically being

made in the numbers of employees at such grade level in all other agencies and departments of the Federal Government combined.".

MEDICAL QUALITY-ASSURANCE RECORDS

SEC. 302. Section 3305 is amended—

(1) in subsection (a), by adding a comma and "other than reports submitted pursuant to section 4152 of this title," after "program"; and

(2) in subsection (b), by adding at the end the following new paragraph:

"(6) Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of statistical information regarding Veterans' Administration health-care programs (including information on aggregate morbidity and mortality rates associated with specific activities at individual Veterans' Administration health-care facilities) that does not implicitly or explicitly identify individual Veterans' Administration patients or employees, or individuals who participated in the conduct of a medical quality-assurance review.".

DISCIPLINARY BOARD ACTION INVOLVING CLINICAL PRIVILEGES

SEC. 303. Section 4110 is amended by adding at the end the following new subsections:

"(f) This section applies in any case in which a reduction or revocation of the clinical privileges of any person employed in a position described in paragraph (1) of section 4104 of this title is proposed by reason of a charge of inaptitude, inefficiency, or misconduct. A disciplinary board may recommend and the Administrator may impose a reduction or revocation of clinical privileges only (1) in a case in which, prior to the hearing under this section, such person has been provided with notice of the proposal to reduce or revoke such privileges, and (2) on the basis of deficiency in such person's clinical practice.

"(g) Nothing in this section shall limit the Administrator's authority to protect the health and safety of veterans by temporarily reassigning an employee for the purpose of suspending the employee's exercise of clinical privileges, or for the purpose of otherwise restricting the employee's clinical activities, pending the outcome of a proceeding under this section.".

QUALITY ASSURANCE AND CREDENTIALING

SEC. 304. (a) Chapter 73 is amended by adding at the end the following new subchapter:

"Subchapter V—Quality Assurance

"§ 4151. Responsibilities for quality assurance

"(a) The Administrator shall—

"(1) establish and conduct a comprehensive quality-assurance program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery;

"(2) delineate the responsibilities of the Department of Medicine and Surgery with respect to the conduct of the Veterans' Administration quality-assurance program; and

"(3) allocate sufficient resources, and sufficient personnel with the necessary skills and qualifications, to enable the Department of Medicine and Surgery to carry out such delineated quality-assurance responsibilities.

"(b) The Inspector General of the Veterans' Administration shall allocate sufficient resources, and sufficient personnel with the necessary skills and qualifications, to enable the Inspector General to monitor the quality-assurance program conducted by the Department of Medicine and Surgery.

"(c) The Administrator shall, as part of the comprehensive quality-assurance program established and conducted pursuant to subsection (a)(1) of this section, require the Chief Medical Director—

"(1) in consultation with the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Armed Forces and other appropriate professional bodies, to establish and maintain a compilation of prevailing national mortality and morbidity standards for each type of surgical procedure conducted by the Department of Medicine and Surgery;

"(2)(A) to collect data on mortality and morbidity rates for each surgical procedure, conducted by the Department of Medicine and Surgery; and

"(B) to compile such data for inclusion in the report to be submitted pursuant to section 4152 of this title (i) for each cardiac surgery, heart transplant, and renal transplant program, and (ii) in the aggregate, for each other such surgical procedure;

"(3) to—

"(A) compare the data so compiled to the standards compiled pursuant to clause (1) of this subsection,

"(B) make an analysis of the relationship between such data and the (i) characteristics of the patient population, (ii) the level of risk for the procedure involved, based on patient age, the type and severity of the disease, the effect of any complicating diseases, and the degree of difficulty of the procedure, and (iii) any other factors that the Chief Medical Director considers appropriate,

"(C) evaluate such data in light of the factors described in divisions (i) through (iii) of subclause (B) of this clause in order to determine whether there are any significant deviations from the standards that would indicate deficiencies in the quality of care, and

"(D) explain any such deviations; and

"(4) to make any recommendations based on data compiled and the comparisons, analyses, evaluations, and explanations made pursuant to clause (3) of this subsection.

"§ 4152. Reports

"(a) Not later than January 1 of 1987, 1989, and 1991, the Chief Medical Director shall submit a report to the Administrator on the experience through the end of the prior fiscal year under the quality-assurance program carried out pursuant to section 4151(a) of this title. Each such report shall include the data compiled and the comparisons, analyses, evaluations, and explanations made pursuant to subsection (c)(3) of section 4151 of this title with respect to the period covered by such report and any recommendations made pursuant to subsection (c)(4) of such section. Not later than 60 days after receiving each such report, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a copy of the report, together with any comments concerning the report that the Administrator considers appropriate.

"(b) A report submitted pursuant to subsection (a) of this section shall not be considered a record or document as described in section 3305(a) of this title.".

(b) The table of sections at the beginning of chapter 73 is amended by adding at the end the following:

"SUBCHAPTER V—QUALITY ASSURANCE

"4151. Responsibilities for quality assurance.
"4152. Reports.".

(c)(1) Not later than 90 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report describing in detail the Veterans' Administration's current efforts and future plans for monitoring the credentials of Veterans' Administration health-care professionals.

(2) The report required to be submitted by paragraph (1) shall include a description of the Veterans' Administration's policies, procedures, and formal arrangements regarding the exchange of relevant information with—

(A) appropriate State medical or other health-professional licensing bodies;

(B) the Federation of State Medical Boards;

(C) the American Medical Association; and

(D) such other public or private entities as the Administrator considers appropriate that are involved with the issuance or monitoring of health-care professional licenses

in order (i) to determine the current and past licensure and clinical privilege status for those health-care professionals who are seeking employment with or who are currently employed by the Veterans' Administration, and (ii) to provide appropriate information to such entities about each health-care professional whose employment with the Veteran's Administration is terminated—

(I) following the completion of a disciplinary action relating to such health-care professionals clinical competence,

(II) voluntarily after having had such health-care professionals clinical privileges restricted or revoked, or

(III) voluntarily after serious concerns about such health-care professionals clinical competence have been raised but not resolved.

(3) With reference to any policies, procedures, or formal arrangements described in paragraph (2) which have not been implemented at the time the report required to be submitted by paragraph (1) is submitted to the Committees, the Administrator shall include in the report a timetable for the implementation of such policies, procedures, and arrangements and shall thereafter report to the Committees on implementation progress every 3 months until full implementation is achieved, at which point a final such report shall be submitted to the Committees.

TITLE IV—MEDICAL FACILITY CONSTRUCTION AND PLANNING

PART A—PERMANENT ANNUAL AUTHORIZATION PROCESS

ANNUAL VETERANS' ADMINISTRATION MEDICAL FACILITY CONSTRUCTION AUTHORIZATIONS

SEC. 401. (a) Section 5004 is amended—

(1) in subsection (a)—

(A) in clause (1), by striking out "unless each committee has first adopted a resolution approving such construction, alteration, or acquisition and setting forth the estimated cost thereof; and" and inserting in lieu thereof "except as authorized by a law based on legislation reported from the committees setting forth the amount that may be appropriated and expended for such construction, alteration, or acquisition;"; and

(B) by redesignating clause (2) as clause (4) and inserting the following new clauses (2) and (3):

"(2) no funds may be expended to construct, remodel, extend, or acquire, or develop preliminary plans (except to the extent necessary to develop project requirements) for, a medical facility for the furnishing of hospital care if the construction, remodeling, extension, or acquisition involves a total expenditure of more than $20,000,000, except as authorized by a law based on legislation reported from the committees;

"(3) no new or replacement medical facility shall be constructed or acquired within excess of 700 hospital beds and no project that involves a total expenditure of more than $20,000,000 for remodeling or extending a medical facility for the furnishing of hospital care shall be undertaken if upon completion of such project the number of hospital beds at the facility would exceed 700; and";

(2) by amending subsection (c) to read as follows:

"(c) The contract price for any construction, alteration, lease, or other acquisition that is approved by a law or resolutions described in subsection (a) of this section may exceed the amount set forth pursuant to such subsection in the pertinent provisions of such law or resolutions by an amount determined by multiplying such amount by the lesser of (1) the percent, if any, as determined by the Administrator, by which construction, alteration, lease, or other acquisition costs, as the case may be, increased from the date of such approval to the date of contract, or (2) 10 percent."; and

(3) in subsection (d) by striking out "for construction, alteration, lease, or other acquisition by each committee under subsection (a) of this section" and inserting in lieu thereof "by each committee under subsection (a) of this section for a lease".

(b)(1) Except as provided in paragraph (2) of this subsection, the amendments made by subsection (a) shall take effect on October 1, 1986.

(2) The amendments made by subsection (a)(1) shall take effect with respect to appropriations for fiscal year 1987 but shall not apply with respect to appropriations or expenditures for the construction, alteration, or acquisition of a medical facility if such construction, alteration, or acquisition was approved in resolutions adopted by the Committees on Veterans' Affairs of the Senate and the House of Representatives prior to September 30, 1985.

VETERANS' ADMINISTRATION HOSPITAL FACILITY PLANNING

SEC. 402. (a) Subchapter I of chapter 81 is amended by inserting after section 5004 the following new section:

"§ 5004A. Hospital facility planning

"(a) In order to ensure that decisions regarding the need for and size of each proposed new or replacement Veterans' Administration medical facility for the furnishing of hospital care are made taking into account appropriate statutory eligibility and priorities for health care from the Veterans' Administration, the Administrator of Veterans' Affairs and the Comptroller General of the United States, after consul-

tation with the Assistant Secretary of Defense for Health Affairs, veterans' service organizations, and representatives of the private hospital industry, shall jointly develop and submit to the appropriate committees of the Congress a methodology for determining the appropriate types of hospital beds and the appropriate numbers of each type of hospital bed to be provided for in each proposed project for the construction of new or replacement facilities for the furnishing of hospital care by the Veterans' Administration.

"(b) The methodology developed pursuant to subsection (a) of this section shall take into account (1) the projected need for health care of veterans residing in the geographic area to be served by the proposed health-care facility who have service-connected disabilities and veterans residing in such areas who meet the income criteria for the receipt of pension under chapter 15 of this title, and (2) any recent or planned changes in treatment modalities for the furnishing of inpatient and outpatient care which might affect the demand for inpatient bed capacity.

"(c)(1) Not later than October 1, 1986, the Administrator and the Comptroller General shall submit to the appropriate committees of the Congress a joint report on the methodology developed pursuant to subsection (a) of this section.

"(2) Not later than October 1, 1987, the Administrator and the Comptroller General shall submit to such committees a joint report on the implementation of such methodology.

"(3) The Comptroller General shall submit to such committees such further reports as the Comptroller General considers appropriate regarding the implementation of such methodology or regarding the need to revise such methodology.

"(d) No funds may be expended after April 1, 1987, for the development of preliminary plans for a facility described in subsection (a) of this section unless the types of beds and number of each type to be provided in such facility are based on the methodology developed pursuant to subsection (a) of this section.".

"(b) The table of sections at the beginning of chapter 81 is amended by inserting after the item relating to section 5004 the following:

"5004A. Hospital facility planning.".

PART B—FISCAL YEAR 1986 CONSTRUCTION AUTHORIZATIONS

VETERANS' ADMINISTRATION MEDICAL FACILITY CONSTRUCTION AUTHORIZATIONS FOR FISCAL YEAR 1986

SEC. 411. (a) For the purposes of the medical facility construction projects referred to in subsection (b) and other construction projects and for other purposes, there are authorized to be appropriated to the Veterans' Administration for fiscal year 1986 (1) $417,200,000 to any appropriations account from which payments for medical facility construction projects estimated to cost $2,000,000 or more are made, and (2) $194,400,000 to any appropriations account from which payments for medical facility construction projects estimated to cost less than $2,000,000 are made.

(b)(1) Except as provided in paragraph (2) and subject to the limitation in subsection (a)(1), the maximum amounts authorized to be appropriated and expended for the following medical facility construction projects are as follows:

(A) Houston, Texas (Replacement and Modernization), $226,800,000.

(B) Mountain Home, Tennessee (Bed Towers and Modernization), $59,000,000.

(C) Philadelphia, Pennsylvania (Clinical Addition, Renovation, Parking, and 240-bed Nursing Home Care Unit), $110,400,000.

(2) Subject to paragraph (3) and to the limitation in subsection (a)(1), the maximum amounts authorized to be appropriated and expended for the following projects are further limited as follows:

(A) Houston, Texas (Replacement and Modernization), $170,400,000.

(B) Mountain Home, Tennessee (Bed Towers and Modernization), $35,800,000.

(C) Philadelphia, Pennsylvania (Clinical Addition, Renovation, Parking, and 240-bed Nursing Home Care Unit), $85,600,000.

(3) The maximum amount set forth in paragraph (2) with respect to each project shall apply to that project unless the Administrator of Veterans' Affairs, not later than 60 days after the date of the enactment of this Act, submits to the appropriate committees of the Congress a certification by the Administrator with respect to the project that a contract for work on the physical structure or structures in which hospital care is to be furnished at a bedsize level consistent with such maximum amounts cannot feasibly be awared within 180 days after (i) the date on which a contract for such construction work was scheduled as of June 1, 1985, to be awarded for the projects described in paragraphs (2)(A) and (B), and (ii) September 1, 1986, for the project described in paragraph (2)(C). Such certification shall be accompanied by

submissions of three architectural/engineering firms (one of which is the firm retained by the Veterans' Administration to complete the plans for the project, one of which is a firm selected by the American Institute of Architects at the Administrator's request, and one of which is a firm selected by the Comptroller General of the United States), at least two of which support the Administrator's certification.

(c) Funds are authorized to be expended in fiscal year 1986 from the working reserve in the Veterans' Administration construction, major projects, account, to the extent consistent with and permitted pursuant to applicable provisions of law in effect on the date of the enactment of this Act, for the redesign of projects identified in paragraph (2) of subsection (b) and for the following projects if the total estimated expenditures involved in the completion of each project as redesigned is no more than the applicable amount specified for such project in such paragraph or as follows:

(1) Augusta, Georgia (Replacement Medical Center), $94,000,000.

(2) Baltimore, Maryland (Replacement Medical Center), $88,800,000.

(3) New York, New York (Outpatient/Clinical Additions and Alterations), $70,600,000.

PART C—ALTERNATIVES TO AND FOR CONSTRUCTION

CONSIDERATION OF PURCHASING OR LEASING MEDICAL FACILITIES

SEC. 421. (a) Section 5002 is amended by adding at the end the following new subsection:

"(d)(1) In connection with the assessment of the health-care needs of veterans in a particular area for the purpose of planning how best to meet such needs the Administrator shall develop criteria for determining whether to proceed with planning for the construction or acquisition of a new or replacement medical facility and, if it is determined to proceed, for choosing among the alternatives of constructing the facility, leasing an existing medical facility that satisfies the requirements of paragraph (3) of this subsection, or purchasing an existing medical facility that satisfies such requirements.

"(2) After January 1, 1986, the Administrator shall not proceed to develop preliminary plans for a new or replacement medical facility except in accordance with the criteria established under paragraph (1) of this subsection and after considering the option of leasing or purchasing an existing facility that satisfies the requirements of paragraph (3) of this subsection.

"(3) A facility satisfies the requirements of this paragraph if—

"(A) the facility is available, or will be available in timely fashion in the foreseeable future, for purchase or lease;

"(B) the facility meets the current and projected needs and specifications of the Veterans' Administration for furnishing health care to eligible veterans residing within a 100-mile radius of where the new or replacement facility is planned to be located, or is adaptable to meet such needs and specifications;

"(C) the facility can be acquired at an estimated cost (including the costs of any necessary adaptation) that does not exceed the estimated cost of construction of a medical facility to meet such needs and specifications; and

"(D) the estimated cost of operating the facility (after adaptation, if necessary) does not exceed the estimated cost of operating a medical facility that would otherwise be constructed.".

(b) Clause (1) of section 5004(b) is amended by inserting "and, in the case of a prospectus proposing the construction of a new or replacement medical facility, a description of the consideration that was given, pursuant to criteria established under section 5002(d) of this title, to acquiring an existing facility by lease or purchase" after "such facility".

CONTRACT FOR CONSTRUCTION AND OPERATION OF A NURSING HOME

SEC. 422. (a) The Administrator of Veterans' Affairs shall enter into a contract with an appropriate entity for the construction and operation of a facility for furnishing solely to veterans eligible for nursing home care under chapter 17 of title 38, United States Code, nursing home care that meets the current and projected needs and specifications (including those relating to location and site selection) of the Veterans' Administration. The contract shall—

(1) for a 5-year period following the completion of construction, require the contractor to staff, equip, and operate the nursing home in such a manner as to provide the types, levels, and quality of care that would be provided if the facility were being operated directly by the Veterans' Administration;

(2) provide the Administrator with the option to renew the contract for an additional term not to exceed 5 years;

(3) require the Administrator to refer a sufficient number of eligible veterans who require nursing home care to the nursing home to ensure a specific occupancy rate for the nursing home for the term of the contract, which rate shall be approximately equal to the average occupancy rate nationwide for Veterans' Administration nursing homes except that a higher rate may be required if the Administrator determines that such higher rate is in the best interests of the Federal Government;

(4) provide that the per diem rate payable to the contractor by the Veterans' Administration shall not exceed the average daily costs to the Veterans' Administration of operating Veterans' Administration facilities for the furnishing of nursing home care;

(5) provide that all rights, title, and interest in the facility constructed under the contract shall vest in the United States; and

(6) contain such other provisions as the Administrator determines are in the best interests of the United States.

(b) The provisons of subsection (a) shall take effect on October 1, 1985.

FEASIBILITY PLAN FOR THE PURCHASE OF A FACILITY FOR FURNISHING HOSPITAL AND NURSING HOME CARE

SEC. 423. In the documents submitted by the Administrator of Veteran's Affairs to the appropriate committees of the Congress at the time of and in connection with the submission, pursuant to section 1105 of title 31, of the Budget for fiscal year 1987, the Administrator shall provide a feasibility plan for the purchase for Veterans' Administration use of a medical facility that is located in an urban area and is suitable for furnishing both hospital and nursing home care services, and meets the current and projected needs and specifications of the Veterans' Administration for furnishing health care to eligible veterans. In such Budget, the President, as warranted by such feasibility plan, shall include a request for an appropriate amount to purchase such a facility which meets those needs and specifications.

DEVELOPMENT OF MEDICAL-FACILITY MODULAR COMPONENTS

SEC. 424. In order to evaluate the applicability to the Veterans' Administration of the use of modular components in the design and construction of medical facilities for the furnishing of hospital care and to determine the efficiency and cost-effectiveness of that approach, the Administrator of Veterans' Affairs shall, not later than 180 days after the date of the enactment of this Act, enter into a contract for the development of such a modular approach to the planning and design of an appropriate Veterans' Administration medical facility for the furnishing of hospital care.

TITLE V—MISCELLANEOUS PROVISIONS

TECHNICAL, CONFORMING AMENDMENT RELATING TO THE CONTINUING AVAILABILITY OF READJUSTMENT COUNSELING

SEC. 501. Section 612A(g)(1)(B) is amended by striking out "who requested such counseling before such date" and inserting in lieu thereof "who request such counseling".

PAYMENT FOR THERAPEUTIC AND REHABILITATION ACTIVITIES

SEC. 502. (a) Section 618 is amended by adding at the end the following new subsection:

"(g) Notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to this section shall be included in determining annual income for purposes of pension payments.".

(b) The amendment made by subsection (a) shall take effect on October 1, 1985.

REPORT ON FEDERAL GOVERNMENT RESPONSIBILITY TO INDIVIDUALS WHO SERVED WITH VOLUNTARY CIVILIAN ORGANIZATIONS IN VIETNAM

SEC. 503. (a)(1) The purpose of this section is to provide a basis for the executive branch and the Congress to evaluate the question of United States Government responsibility, and alternative approaches, for providing individuals who, for a period of at least 30 days during the Vietnam era, were employed in the Republic of Viet-

nam by (including having served there under the auspices of) voluntary organizations, determined by the Administrator of Veteran's Affairs, in consultation with the Secretary of Defense, to be organizations which provided significant assistance to the United States Armed Forces in the Republic of Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to their experiences during such employment in the Republic of Vietnam), either through the Veterans' Administration or otherwise, and for assisting such individuals in connection with disabilities they may have incurred as a result of such employment.

(2) In order to carry out the purpose stated in paragraph (1), the Administrator, the Secretary of Defense, and the Secretary of Health and Human Services, not later than 180 days after the date of the enactment of this Act, shall submit to the appropriate committees of the Congress a joint report on the question of United States Government responsibility and shall include in such report various alternative approaches (together with comments on the appropriateness and the advantages and disadvantages of each) and any recommendations by such officials for legislative and administrative action with respect thereto, for establishing a program for providing such benefits, services, and assistance to such individuals.

(b) For the purpose of this section—

(1) the term "Armed Forces" has the meaning given such term in section 101(10) of title 38, United States Code; and

(2) the term "Vietnam era" means the periods described in section 101(29) (as amended by section 201(a) of this Act) of such title.

LAND TRANSFER, PHOENIX, ARIZONA

SEC. 504. (a) The real property described in subsection (b) and the structures thereon on the date of the enactment of this Act shall be transferred without compensation or reimbursement from the control and jurisdiction of the General Services Administration to the control and jurisdiction of the Veterans' Administration.

(b) The real property referred to in subsection (a) is a tract of land consisting of 3.25 acres, more or less, in Phoenix, Arizona, that—

(1) was formerly part of the Veterans' Administration Medical Center, Phoenix, Arizona; and

(2) was declared to be excess to the needs of the Veterans' Administration in a report to the General Services Administration dated September 25, 1959.

TITLE VI—EFFECTIVE DATE

SEC. 601. Except as otherwise provided in sections 201(b), 203(b), 401(b), 422(b), and 502(b) of this Act, the provisions of and amendments made by this Act shall take effect on the date of the enactment of this Act.

INTRODUCTION

S. 876 was introduced on April 3, 1985, by the Chairman of the Committee, Senator Frank Murkowski. As introduced, S. 876 would have, first, directed the VA to establish a pilot program to furnish medical, rehabilitative, and social services as an alternative to nursing home care for eligible veterans who would otherwise require nursing home care; second, made permanent the currently authorized halfway house pilot program for veterans with alcohol or drug abuse dependencies or disabilities; third, required the VA to conduct a pilot program to furnish community residential care to certain chronically mentally ill veterans; fourth, required the Administrator to delineate the responsibilities of the Office of the Inspector General and the Department of Medicine and Surgery with respect to the monitoring, evaluation, and conduct of VA quality-assurance programs; and fifth, established a committee of health-care experts to review the VA's criteria and methodology for sizing VA medical facilities.

On January 3, 1985, Senator Alan Cranston, the Committee's Ranking Minority Member, introduced S. 6, which was subsequently cosponsored by Senator Sarbanes, Committee member DeConcini, and Senator Simon. As introduced, S. 6 would have, first, expanded the definition of the Vietnam era for the purposes of title 38, United States Code, so as to include service in Vietnam at any time during the period beginning on February 21, 1961, and ending on August 4, 1964, the day before the starting date of the Vietnam era in current law; second, precluded the Administrator of Veterans' Affairs from implementing any systematic reduction of VA employee pay grades without first submitting to the Veterans' Affairs Committees a plan and justification for the proposed reduction, including a determination that, in the personnel area involved, the VA, in comparison to non-VA employers, has a disproportionate number of employees at the salary levels involved; and directed the Comptroller General to evaluate and comment on any such VA plan, justification, and determination; third, extended for 2½ years, until the end of fiscal year 1989, which is 12 months after the Centers for Disease Control (CDC) plans to submit the results of the Congressionally-mandated epidemiological study, the period during which certain veterans—those exposed to dioxin or other toxic substances in Vietnam during the Vietnam era or to ionizing radiation from nuclear detonations—would be eligible to receive priority VA health-care services for disabilities not determined to be unrelated to such exposure; fourth, extended by 3 years, until the end of fiscal year 1988, the VA's current authority to place veterans with alcohol or drug abuse dependencies or disabilities in non-VA halfway houses and other community-based programs for treatment and rehabilitation, and required annual reports in 1986, 1987, and 1988, on the experience under this authority; fifth, provided that any remuneration received by VA patients in a rehabilitation therapy program under section 618 of title 38 would not be counted as income for the purpose of VA pension programs; sixth, provided that section 3305 of title 38, relating to the confidentiality of certain VA disciplinary proceedings involving physicians and certain other VA medical quality-assurance records, does not authorize or require the withholding by the VA of disclosure of statistical information regarding VA health-care programs, including aggregate morbidity and mortality rates associated with specific activities at individual VA health-care facilities; seventh, provided that procedures set forth in section 4110 of title 38, relating to disciplinary proceedings involving physicians and certain other VA health-care personnel employed under the special title 38 personnel system, would apply in cases involving proposed reductions or revocations of the clinical privileges of such personnel; eighth, required the VA, in order to evaluate various actions that would enable veterans to receive needed health care in noninstitutional settings, to conduct a 48-month pilot demonstration program through which certain veterans would be helped to avoid institutional care through the provision of appropriate health and health-related services from the VA and from appropriate public or private agencies; ninth, directed the Administrator and the Secretaries of Defense and of Health and Human Services to submit to the Congress a joint report on the question of U.S. Government respon-

sibility for disabilities that possibly resulted from their service in Vietnam—such as exposure to Agent Orange or to particularly traumatic events—with voluntary organizations that provided significant assistance to U.S. Armed Forces.

On April 3, 1985, Chairman Murkowski introduced S. 875. As introduced, S. 875 would have required the Administrator to establish a pilot program of 10 Vietnam Veterans' Resource Centers (VVRC) to provide and coordinate certain services for Vietnam-era veterans.

On April 25, 1985, Committee members Boschwitz and Denton introduced S. 1007. As introduced, S. 1007 would have, first, required that the VA's first option when developing plans for new or replacement medical facilities would be to consider leasing or purchasing existing facilities; second, required the VA to establish a pilot program to examine four scenarios of acquiring medical facilities (including a privately built and run nursing home that the VA would contract for; a privately planned, designed, and built nursing home that would be leased to and run by the VA; the purchase of an existing medical facility; and the leasing of an existing facility); and third, required the VA to report on the potential cost savings of increasing the number of nursing home beds contracted for by the VA in community facilities.

On April 1, 1985, Senator Cranston submitted Amendment No. 22 to S. 6. Amendment No. 22 would have made a technical, conforming amendment to section 612A(g)(1)(B) of title 38, relating to planning for the continuing availability of VA readjustment counseling services for Vietnam-era veterans.

On May 2, 1985, Committee member Strom Thurmond introduced S. 1052. As introduced, S. 1052 would have, first, authorized the VA to conduct five demonstration projects to provide chiropractic services to eligible veterans; second, required the VA to enter into cooperative agreements with no less than five chiropractic colleges to coordinate services; and third, required the chiropractic colleges to perform clinical research and data collection regarding the therapeutic benefits and cost-effectiveness of such service.

On March 26 and 27, 1985, the Committee held hearings, chaired by Senator Murkowski, to receive testimony on matters pertaining to construction of VA medical facilities. Testimony was received on March 26 from Senator Paul Sarbanes of Maryland; Dr. John Ditzler, Chief Medical Director of the VA; and representatives of The American Legion, the Veterans of Foreign Wars of the United States, the Disabled American Veterans, and the Paralyzed Veterans of America.

On March 27, testimony was received from Senators Lloyd Bentsen and Phil Gramm of Texas; Dr. John Gronvall, Deputy Chief Medical Director of the VA; and O. David West, Ph.D., Director, Special Projects, and Tom Batey, Vice President, Planning and Construction, of the Hospital Corporation of America.

In addition, on May 7, 1985, the Committee held a hearing, chaired by Senator Murkowski, to receive testimony on S. 6, Amendment No. 22 to S. 6, S. 875, S. 876, S. 1007, and S. 1052. Testimony was received from Dr. John Gronvall, Deputy Chief Medical Director of the VA; Dr. Melvin Sabshin, Medical Director, American Psychiatric Association; Orville Lips, Ph.D., Chief, Psychologi-

cal Services, VAMC North Chicago, Illinois, and President of the Association of VA Chief Psychologists also representing the American Psychological Association; David Baine, Associate Director, General Accounting Office; and representatives of The American Legion, the Veterans of Foreign Wars of the United States, the Disabled American Veterans, AMVETS, the Paralyzed Veterans of America, and the Vietnam Veterans of America.

After carefully reviewing the testimony, the Committee met in open session on June 12, 1985, and voted unanimously to report favorably S. 876, Amendment No. 22 to S. 6, S. 875, S. 876, S. 1007, S. 1052, as well as provisions relating to former prisoners of war and a land transfer in Phoenix, Arizona.

Summary of S. 876 as Reported

The Committee bill has six titles: Title I, Pilot Programs; Title II, Extension of Expiring Authorities and Eligibilities; Title III, Health-Care Management; Title IV, Medical Facility Construction and Planning; Title V, Miscellaneous Health-Care Amendments; and Title VI, Effective Dates, as follows:

Title I: *Pilot Programs.*—This title would provide for the establishment of 4 pilot programs, all of which are designed to provide an opportunity to test and evaluate alternative ways of providing health and health-related services to eligible veterans. Included in title I of the Committee bill are provisions that would:

1. Require the Administrator to conduct a 3-year program under which the VA would increase the range of services provided at 10 VA readjustment counseling centers for Vietnam-era veterans (Vet Centers) so that, in addition to providing readjustment counseling, these demonstration centers would provide eligible veterans with assistance in applying for other benefits and services; establish a coordinating committee to oversee this program; and require the Administrator to submit a report on the program by April 1, 1987.

2. Authorize a 4-year pilot program through which the VA would be authorized to furnish certain service-connected chronically mentally ill veterans with treatment and rehabilitation in community-based psychiatric residential treatment facilities and require the Administrator to submit an interim report on the program by February 1, 1989, and a final report by April 1, 1990.

3. Require the Administrator to conduct a 4-year pilot program through 10 demonstration project under which veterans eligible for and otherwise in need of VA hospital, nursing home, or domiciliary care, would instead receive care, including health-related services from non-VA entities, in noninstitutional settings; provide a priority for such care and services to veterans with service-connected disabilities, to veterans who are 65 or older, and to veterans who are totally and permanently disabled; direct the utilization of VA geriatric evaluation units as part of 5 of the projects and the assignment of VA employees to provide case management services for all veteran-participants; and require the Administrator to submit an inter-

im report on the program by February 1, 1989, and a final report by April 1, 1990.

4. Require the Administrator to conduct a 3-year pilot program, with at least one demonstration project in each of 5 geographic regions, for providing for the reimbursement (or direct payment) of reasonable charges for chiropractic services, not otherwise covered by available health insurance or other reimbursement, provided by non-VA providers to certain veterans with neuromusculoskeletal conditions of the spine; limit the amount payable for authorized chiropractic services furnished an individual veteran to $600 per 12-month period and the total VA expenditures for chiropractic services (to be made from funds appropriated for beneficiary travel) to $2 million in any fiscal year; and require 3 annual reports on the program.

Title II: *Extensions of Authorities and Eligibilities.*—This title would provide for extensions of certain expiring authorities and of certain eligibilities. Included in title II of the Committee bill are provisions that would:

1. Expand the definition of the Vietnam-era for the purposes of title 38, United States Code, to include the period beginning on February 21, 1961, and ending on August 4, 1964, in the case of those who served in Vietnam during that time.

2. Extend for 2½ years, through fiscal year 1989, the period during which certain veterans—those exposed to dioxin or other toxic substances in Vietnam or to ionizing radiation from nuclear detonations—would be eligible to receive priority VA health-care services for disabilities not determined to be unrelated to such exposure.

3. Authorize the Administrator to furnish counseling, upon request, to any veteran who is a former prisoner of war to assist the veteran in overcoming the psychological effects of the prisoner-of-war experience.

4. Extend for 3 years, through fiscal year 1988, the VA's authority, currently a pilot-program authority, to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependency disabilities; require a report not later than February 1, 1988, on the authority; and delete references to this program as a "pilot" program.

Title III: *Health-Care Management.*—This title would improve the Veterans' Administration's health-care management efforts. Included in title III of the Committee bill are provisions that would:

1. Require the Administrator to submit a report to the Congress prior to implementing any systematic reduction in the pay grades of certain VA employees—direct and indirect health-care personnel, attorneys, and engineers—and to include in the report, to be evaluated by the Comptroller General, a detailed plan and justification for the proposed reduction and a determination that in the personnel area involved the VA, in comparison to non-VA employers, has a disproportionate number of employees at the salary level from which reductions would be made; and as to categories of VA employees not covered by this reporting requirement, preclude the Administrator from implementing a systematic pay-grade reduction at

a rate greater than any pay-grade reduction made with respect to all other Federal employees at the same pay grade.

2. Provide that existing statutory limitations on the disclosure of certain VA quality-assurance records do not apply to statistical information regarding VA health-care programs, including aggregate morbidity and mortality rates associated with specific activities at individual VA health-care facilities if the information does not explicitly or implicitly identify any VA patient or employee or individual involved with VA quality-assurance efforts.

3. Provide that existing statutory procedures relating to disciplinary proceedings against physicians and certain other VA health-care personnel would apply in cases involving proposed reductions or revocations of the clinical privileges of such personnel and limit restrictions on clinical privileges to cases involving a deficiency in an individual's clinical practice.

4. Require the Administrator to establish a comprehensive quality-assuance program to monitor the quality of VA health care and to provide sufficient resources to carrying out such a program; require the VA's Chief Medical Director, as part of this program, to compile national mortality and morbidity standards for all types of surgical procedures carried out by the VA, collect local and national mortality and morbidity data for VA surgical programs and compile such data in certain prescribed ways, compare the compilations of such data with the national standards, evaluate any differences between the VA data and the national standards, and submit to the Administrator on January 1, 1987, 1989, and 1991, reports on the quality-assurance program; require the Administrator to submit the Chief Medical Director's reports to the Congress; and require the VA's Inspector General to allocate sufficient resources to monitoring the quality-assurance program.

5. Require the Administrator, within 90 days after the date of enactment, to submit to the Committees on Veterans' Affairs a report on the VA's current efforts and future plans for monitoring the credentials of VA health-care personnel and, with reference to any policy, procedure, or formal arrangement relating to such activity not implemented by the date of the report, require reports every 3 months until full implementation.

Title IV: *Medical Facility Construction and Planning.*—This title would provide for various improvements in the VA's health-care facility construction program.

PART A—PERMANENT ANNUAL AUTHORIZATION PROCESS

Part A of this title includes provisions that would:

1. Provide for annual statutory authorizations of appropriations—in lieu of House of Representatives and Senate Veterans' Affairs Committees resolutions of approval—for major VA medical facility construction, alteration, or acquisition projects (those costing over $2 million). Under this provision, no appropriation could be made for such a project except in accordance with a law based on legislation reported from the Committees

on Veterans' Affairs setting forth the maximum amount that may be appropriated and expended for the project.

2. Prohibit any expenditure, beyond what is necessary to develop project requirements, for a project costing $20 million or more for the construction, remodeling, expansion, or acquisition of a VA hospital facility unless authorized by a law based on legislation reported from the Committees on Veterans' Affairs.

3. Limit to not more than 700 hospital beds the size of new or replacement VA hospital facilities that could be constructed and prohibit projects involving expenditures of over $20 million for the remodeling or expansion of a VA facility where, upon completion of the project, the facility would have more than 700 hospital beds.

4. Require the Administrator and the Comptroller General, not later than October 1, 1986, to develop and submit to the Congress a methodology for determining the appropriate number and types of hospital beds to be provided for in the construction of a new or replacement VA hospital facility; require the methodology to take into account the projected health-care needs of service-connected disabled veterans and financially needy veterans in the catchment area; require the Comptroller General to report not later than October 1, 1987, on the implementation of the methodology, and thereafter as appropriate; and preclude the expenditure of funds after April 1, 1987, for preliminary plans for a new or replacement VA hospital facility unless the number and type of beds in such facility are based in the required methodology.

PART B—FISCAL YEAR 1986 CONSTRUCTION AUTHORIZATIONS

Part B of this title includes provisions that would authorize the appropriation of the total amounts requested for the VA's major and minor construction accounts in the President's budget for fiscal year 1986 and, within the total amount so authorized for fiscal year 1986, authorize appropriations for and place certain statutory limitations on the amounts that may be appropriated and expended for specified major replacement/modernization projects.

PART C—DEMONSTRATION PROJECTS AND ACTIVITIES

Part C of this title includes provisions that would:

1. Require the Administrator to develop criteria for determining when a new or replacement medical facility is needed and, if so, for deciding which option to select—new construction or the purchase or lease of an existing facility which meets certain specified requirements—and to apply those criteria in the development after January 1, 1986, of plans for new and replacement medical facilities.

2. Require the Administrator to enter into a contract with an appropriate entity for the construction and operation—for up to 10 years following completion of construction—of a nursing home meeting the needs and specifications of the VA.

3. Require the Administrator to submit, in connection with fiscal year 1987 budget request, a feasibility study for the pur-

chase of an urban medical facility suitable for providing both hospital and nursing home care and meeting certain VA specified requirements, and require that, as warranted by the study results, the fiscal year 1987 budget request include an appropriate amount for such purchase.

4. Require the VA to enter into a contract for the development of a modular approach for the planning and design of VA hospitals in order to evaluate the applicability and cost-effectiveness of this approach and its use in the VA's design and construction processes.

Title V: *Miscellaneous Health-Care Amendments.*—Included in title V of the Committee bill are provisions that would:

1. Make a technical amendment to clarify that the Administrator is responsible for planning for the continuing availability for readjustment counseling services after September 30, 1988, of veterans requesting such assistance without reference to when they initially request it.

2. Specify that any remuneration provided to veterans for participation in certain VA work-therapy programs will not be counted as income for the purposes of VA pension programs.

3. Direct the Administrator and the Secretaries of Defense and of Health and Human Services, within 180 days after enactment, to submit a joint report on the question of U.S. Government responsibility for providing benefits for disabilities which may be related to the experiences of individuals who were present in Vietnam for at least 30 days as employees of voluntary organizations and, to the extent such responsibility is identified, on how Federal or other benefits should be provided.

4. Provide for the transfer, at no cost to the VA, of a certain parcel of land in Phoenix, Arizona, from the General Services Administration to the VA.

Title VI: *Effective Dates.*—Included in title VI of the Committee bill is a provision that would provide that, except as specified in the provisions described in the summaries of items 1 and 3 of title II, item 2 of part C of title II, and item 2 of title V, above, the provisions in the Committee bill will take effect upon enactment.

Discussion

TITLE I—PILOT PROGRAMS

Vietnam Veteran Resource Centers

Section 101 of the Committee bill, which is derived from S. 875, would require the Administrator to conduct a 3-year pilot program, beginning January 1, 1986, and ending December 31, 1988, under which the Administrator would designate 10 already existing readjustment counseling centers (Vet Centers) as demonstration Vietnam Veteran Resource Centers (VVRC's). These centers would provide to eligible Vietnam-era veterans, in addition to readjustment counseling and related mental health services, the following: (1) counseling and assistance relating to all VA benefits and services; (2) employment counseling, training, placement, and other services provided by the Department of Labor; (3) intake, referral, and fol-

lowup services for veterans with alcohol and drug abuse related disabilities; and (4) coordination of services received by veterans participating in the program from other VA programs, Department of Labor programs, and other Federal programs. The Administrator would also be required to establish a VVRC Coordinating Committee to assist the Administrator in the development and implementation of the program.

Background

Public Law 96-22, the Veterans' Health Care Amendments of 1979, established a program of readjustment counseling and related mental health services for Vietnam-era veterans. Veterans eligible for the program had 2 years, until September 30, 1981, to make an initial request for readjustment counseling services. Public Law 97-72, the Veterans' Health Care, Training and Small Business Loan Act of 1981, extended the period of eligibility to request such counseling by 3 years until September 30, 1984. That law also required the Administrator to report to the Congress by April 1, 1984, on the steps taken to ensure the orderly transition by October 1, 1984, of the Vet Center program from one providing counseling primarily in "storefront" centers to one providing the counseling primarily through VA medical facilities. Most recently, Public Law 98-160, the Veterans' Health Care Amendments of 1983, extended the storefront readjustment counseling centers in their present format for an additional 4 years until September 30, 1988, and modified the due date, until April 1, 1987, of the report on the future of the program in the Vet Center format. That law also eliminated the expiration date for the period during which eligible Vietnam-era veterans may request readjustment counseling, thereby providing Vietnam-era veterans with ongoing eligibility to request such counseling. Last year, in the Committee's Views and Estimates submitted to the Budget Committee on March 15, 1984, on the VA's fiscal year 1985 budget, and in recommendations transmitted to the Senate Appropriations Committee, Committee members recommended a reallocation of $7.2 million and 220 full-time equivalent employees (FTEE) for the readjustment counseling program. As a result, the VA is expected to have a total of 187 Vet Centers and satellite clinics by the end of the fiscal year 1985.

According to Veterans' Administration statistics, over 375,000 persons were seen by the Vet Center program over the 5-year period from January 1980 to January 1985. Use of the Vet Center program by veterans and family members increased from fiscal year 1983 to fiscal year 1984. In fiscal year 1983, an average of 5,800 new clients were seen per month nationwide. In fiscal year 1984, the number of new clients seen per month was 6,300. Similarly, the average number of total veterans seen per month increased from an average of approximately 17,000 in fiscal year 1983 to approximately 19,000 in fiscal year 1984. The VA's most recent tabulation of problems presented by Vet Center clients indicated that 41.7 percent of the problems were related to vocational or employment difficulties. Approximately 23.7 percent of the presenting problems were questions about VA benefits and services. And another 16.6 percent of the problems were related to the use of alcohol or drugs.

The VA's most recent tabulation of problems presented by Vet Center clients indicated the following percentages with the following key problems:

	Percent
Marital	15.5
Anxiety/fear	34.7
Bad dreams/flashbacks	15.7
Vocational	41.7
VA questions	23.7
Alcohol/drugs	16.6
Interpersonal	31.6
Educational	10.2
Financial	11.7
Mental	14.1
Agent Orange	7.1
Suicide/homicide	5.7
Legal	6.7
Skill training	3.5
Discharge upgrade	2.4

(Percentages add to to more than 100 due to veterans presenting with problems in more than one category.)

Committee bill

The Committee believes that the above statistics clearly demonstrate that in a significant percentage of cases, veterans seeking assistance at VA Vet Centers often present problems requiring services in addition to psychological counseling. The provisions of the Committee bill requiring the establishment of 10 demonstration of VVRC's at Vet Centers are designed to provide for the furnishing of such services. The Committee believes that providing a broad spectrum of services in addition to psychological counseling at the VVRC demonstration sites would offer a promising way of more appropriately addressing the needs of certain Vietnam-era veterans seeking help at the Vet Centers. A "one-stop" service approach would facilitate and expedite the referral and assistance processes by which eligible Vietnam-era veterans could receive services appropriate to meet their variety of needs. The Committee bill would provide local Vet Center and VA program managers with complete flexibility to coordinate the provision of these services in the most effective and efficient manner possible at the VVRC sites.

The VVRC pilot program is designed to explore the approach of multi-service delivery. During the pilot program, veterans who are served in the 10 demonstration sites would have the advantage of receiving a variety of VA benefits and services. Although 120 Vet Centers now have a Department of Labor employee working at the Vet Center performing employment counseling and a number of other Vet Centers have a Department of Veterans' Benefits counselor providing benefits counseling, the Committee believes this arrangement should be formalized and conducted in a systematic way in the demonstration projects. Also, the Committee notes that the Committee bill would provide the VA with flexibility to determine the most appropriate program sites, but the Committee intends that the VA select sites which vary in location and are geographically dispersed and ensure that each VA Region has at least one such site. The Committee also believes it is important for the VA

to consider the needs of veterans residing in rural areas when selecting the sites.

In testimony at the May 7 hearing, Dr. John Gronvall, Deputy Chief Medical Director, stated, "the concept of converting some of the Vet Centers into extended one-stop service centers has a certain appeal." The Committee also notes the general support for the principle of the VVRC pilot program expressed by representatives of certain veterans' service organizations at the Committee's hearing. However, the VA and some veterans' organizations expressed certain reservations about certain specific provisions of S. 875, particularly the provision which directed that the pilot program be administered through the Deputy Administrator. The Committee bill, modified to take these concerns into account, would instead, establish a VVRC Coordinating Committee to ensure the appropriate coordination and implementation of the pilot program. The Coordinating Committee would be composed of individuals appointed by and representing the Administrator, the Chief Medical Director, the Chief Benefits Director, and the Assistant Secretary of Labor for Veterans' Employment and would be required to report to these officials at least once every 6 months on the implementation and status of the pilot program. An important goal of the pilot program is to increase the coordination of services provided by the Department of Medicine and Surgery and the Department of Veterans' Benefits and the Coordinating Committee will further this goal. The Committee is aware of the concerns raised by veterans who have expressed their frustration that they must deal with those two VA departments as if they were separate agencies, which tends to impede and to complicate the process of receiving benefits for which they are eligible.

The Committee believes that information regarding the new one-stop center approach of the VVRC's would be useful in the VA's final report and recommendation regarding the future shape of and the need for the Vet Center program. The Committee bill would thus require that the Administrator's report on the readjustment counseling program, due not later than April 1, 1987, include an evaluation of the effectiveness of the pilot program in providing and coordinating the services provided through the VVRC's as well as the cost-effectiveness of the program, and also include any plans to increase the coordination within the agency generally of such services.

Pilot Program of Community-Based Psychiatric Residential Treatment for Chronically Mentally Ill Veterans

Section 102 of the Committee bill, which is derived from section 4 of S. 876, would provide the Administrator with discretionary authority to operate a 4-year pilot program, beginning January 1, 1986, and terminating December 31, 1989, to contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for certain service-connected veterans suffering from chronic mental illness. Also, this section would require the Administrator to submit to the Congress,

not later than February 1, 1989, an interim report on the program and, not later than April 1, 1990, a final report on the program.

Background

The initial findings, released in 1984, of a major study conducted by the National Institute of Mental Health of more than 10,000 individuals found that 19 percent, or almost one-fifth, of the adult American population residing in urban areas suffers, within a 6-month period, from at least one diagnosable mental disorder. During fiscal year 1984, 23,689 or nearly 30 percent of the VA's 79,214 operating hospital beds were used for the psychiatric treatment of veterans. According to VA's 1984 Medical District Initiated Planning Process (MEDIPP) data, during the period 1990–2000, the number of VA medical care beds is expected to total 23,629 beds, an increase of 275; the number of VA surgical care beds is expected to total 16,325 beds, an increase of 33 beds; and the number of VA psychiatric care beds is expected to total 24,075 beds, an increase of 319. According to the VA, approximately 34 percent of the VA's nursing home care patient population and more than 60 percent of VA domiciliary patients have a psychiatric diagnosis, although not necessarily as their primary diagnosis.

According to preliminary findings of both a VA Inspector General audit of psychiatric inpatient care, which began on September 17, 1984, and preliminary findings of a General Accounting Office review of the extent to which VA psychiatric patients are being treated at appropriate levels of care, which began in December 1984, at least 25 percent of VA hospitalized psychiatric patients are inappropriately placed and need a less acute level of care. The Committee believes that many do not have a medical need to be institutionalized and that inappropriate placements are a result of difficulties in placing such veterans in appropriate community settings due to one or a combination of the following factors:

—Lack of financial resources.

—Lack of available supportive family or other social support network.

—Community reluctance or opposition to having chronic psychiatric patients reside in the community.

Public Law 98–160, the Veterans' Health Care Amendments of 1983, enacted on November 21, 1983, provided the VA with the discretionary authority to refer veterans to and aid veterans in obtaining placement, but not to finance their care, in community residential care facilities. Section 4 of S. 876 as introduced would have required the VA to conduct a pilot program in five geographic areas to pay for the community residential care of certain chronically mentally ill veterans. Veterans would have been eligible to receive care under the pilot program if they were suffering from chronic mental illness and were eligible for VA hospital, nursing home, or domiciliary care, if they would be in a VA hospital or nursing home without receiving the care under the pilot program, and if they would be able to live at home in a substantially self-sufficient manner as a result of receiving care under the pilot program. The program would have provided certain chronically mentally ill veterans with the opportunity to reside in an environment less restrictive than that of a VA hospital, nursing home, or domi-

ciliary and at the same time receive the necessary supportive services that may be critical to successful deinstitutionalization of such patients.

Testimony provided at the Committee's May 7 hearing by Dr. Melvin Sabshin, Medical Director, American Psychiatric Association (APA), summarized APA's views concerning the needs and treatment efforts of chronically mentally ill patients:

> We believe that these individuals, whether veterans or non-veterans, should be treated in the least restrictive setting, which we believe . . . means optimum therapeutic setting and thus assures that psychiatric patients receive meaningful and appropriate treatment, whether in inpatient or in community-based facilities and programs. We have long advocated the need for a comprehensive community support system to meet the needs and develop the potential of our nation's large population of chronically mentally ill.
>
> Our society has, unfortunately, made many tragic mistakes in trying to achieve this goal over the past few years. The era of deinstitutionalization in the 1950's and 1960's was ushered in with much naivete and many simplistic notions as to what would become of the chronically and severely mentally ill in new community settings. The importance of psychoactive medication and a stable source of support was perceived but the importance of developing such fundamental resources as supportive living arrangements was often not clearly seen, or at least not implemented. As a result, the dilemma of what to do with the chronically mentally ill is even more acute today, and can be perhaps most obviously evidenced by the growing numbers of homeless mentally ill on our streets. Regrettably, our nation's veterans are no exception to this problem. In fact, I understand it has been estimated that up to 50 percent of New York City's homeless population may be veterans.

Dr. Sabshin further stated that the APA has found that many chronically mentally ill persons for whom institutionalization is not appropriate would be able to make a successful transition into the community if certain alternative services were provided or made available to them. The specific recommendations of APA's Task Force on the Homeless Mentally Ill, set forth below, should be a general guide to the VA in implementing the new authority provided by the Committee bill.

Recommendations of APA's Task Force on the Homeless Mentally Ill

Following are the recommendations of the American Psychiatric Association's task force on the homeless mentally ill. The recommendations, which represent the consensus of the task force members, are contained in the task force report, *The Homeless Mentally Ill*, to be published this fall.

Major recommendation

To address the problems of the homeless mentally ill in America, a comprehensive and integrated system of care for this vulnerable population of the mentally ill, with designated responsibility, with accountability, and with adequate fiscal resources, must be established.

Derivative recommendations

1. *Any attempt to address the problems of the homeless mentally ill must begin with provisions for meeting their basic needs: food, shelter, and clothing.* The chronically mentally ill have a *right*, equal to that of other groups, to these needs being met.

2. *An adequate number and ample range of graded, stepwise, supervised community housing settings must be established.* While many of the homeless may benefit from temporary housing such as shelters, and some small portion of the severely and chronically mentally ill can graduate to independent living, for the vast majority neither shelters nor mainstream low-cost housing are appropriate. Most housing settings that require people to manage by themselves are beyond the capabilities of the chronically mentally ill. Instead, there must be settings offering different levels of supervision, both more and less intensive, including quarterway and halfway houses, lodges and camps, board-and-care homes, satellite housing, foster or family care, and crisis or temporary hostels.

3. *Adequate, comprehensive, and accessible psychiatric and rehabilitative services must be available, and must be assertively provided through outreach services when necessary.* First, there must be an adequate number of direct psychiatric services, both on the streets and in the shelters, when appropriate, that provide (a) outreach contact with the mentally ill in the community, (b) psychiatric assessment and evaluation, (c) crisis intervention, including hospitalization, (d) individualized treatment plans, (e) psychotropic medication and other somatic therapies, and (f) psychosocial treatment.

Second, there must be an adequate number of rehabilitative services, providing socialization experiences, training in the skills of everyday living, and social rehabilitation. Third, both treatment and rehabilitative services must be provided assertively—for instance, by going out to patients' living settings if they do not or cannot come to a centralized program. And fourth, the difficulty of working with some of these patients must not be underestimated.

4. *General medical assessment and care must be available.* Since we know that the chronically mentally ill have three times the morbidity and mortality of their counterparts of the same age in the general population, and the homeless even higher rates, the ready availability of general medical care is essential and critical.

5. *Crisis services must be available and accessible to both the chronically mentally ill homeless and the chronically mentally ill in general.* Too often, the homeless mentally ill who are in crisis are ignored because they are presumed, as part of the larger homeless population, to reject all conventional forms of help. Even more inappropriately, they may be put into inpatient hospital units when rapid, specific interventions such as medication or crisis housing would be more effective and less costly. Others, in need of acute hospitalization, are denied it because of restrictive admission criteria or commitment laws. In any case, it will be difficult to provide adequate crisis services to the homeless mentally ill until they are conceptualized and treated separately from the large numbers of other homeless persons.

6. *A system of responsibility for the chronically mentally ill living in the community must be established, with the goal of ensuring that ultimately each patient has one person responsible for his or her care.* Clearly the shift of psychiatric care from institutional to community settings does not in any way eliminate the need to continue the provision of comprehensive services to mentally ill persons. As a result, society must declare a public policy of responsibility for the mentally ill who are unable to meet their own needs; governments must designate programs in each region or locale as core agencies responsible and accountable for the care of the chronically mentally ill living there; and the staff of these agencies must be assigned individual patients for whom they are responsible. The ultimate goal must be to ensure that each chronically mentally ill person in this country has one person—such as a case manager or resource manager—who is responsible for his or her treatment and care.

For the more than 50 percent of

the chronically ill population living at home or for those with positive ongoing relationships with their families, programs and respite care must be provided to enhance the family's ability to provide a support system. Where the use of family systems is not feasible, the patient must be linked up with a formal community support system. In any case, the entire burden of deinstitutionalization must not be allowed to fall upon families.

7. *Basic changes must be made in legal and administrative procedures to ensure continuing community care for the chronically mentally ill.* In the 1960s and 1970s more stringent commitment laws and patients' rights advocacy remedied some egregious abuses in public hospital care, but at the same time these changes neglected patients' right to high-quality comprehensive outpatient care as well as the rights of families and society. New laws and procedures must be developed to ensure provision of psychiatric care in the community—that is, to guarantee a right to treatment in the community.

It must become easier to obtain conservatorship status for outpatients who are so gravely disabled and/or have such impaired judgment that they cannot care for themselves in the community without legally sanctioned supervision. Involuntary commitment laws must be made more humane to permit prompt return to active inpatient treatment for patients when acute exacerbations of their illnesses make their lives in the community chaotic and unbearable. Involuntary treatment laws should be revised to allow the option of outpatient civil commitment; in states that already have provisions for such treatment, that mechanism should be more widely used. Finally, advocacy efforts should be focused on the availability of competent care in the community.

8. *A system of coordination among funding sources and implementation agencies must be established.* Because the problems of the mentally ill homeless must be addressed by multiple public and private authorities, coordination, so lacking in the deinstitutionalization process, must become a primary goal. The ultimate objective must be a true system of care rather than a loose network of services, and an ease of communication among different types of agencies (for example, psychiatric, social, vocational, and housing) as well as up and down the governmental ladder, from local through federal. One characteristic of a genuine system is the ability to flexibly alter roles, responsibilities, and programs as specific service needs change, and we must strive for this ultimate end.

9. *An adequate number of professionals and paraprofessionals must be trained for community care of the chronically ill.* Among the additional specially trained workers needed, four groups are particularly important for this population: (a) psychiatrists who are skilled in, and interested in, working with the chronically mentally ill; (b) outreach workers who can engage the homeless mentally ill on the streets; (c) case managers, preferably with sufficient training to provide therapeutic interventions themselves; and (d) conservators, to act for patients too disabled to make clinically and economically sound decisions.

10. *General social services must be provided.* Besides the need for specialized social services such as socialization experiences and training in the skills of everyday living (referred to in Recommendation 3), there is also a pressing need for generic social services. Such services include escort services to agencies and potential residential placements, help with applications to entitlement programs, and assistance in mobilizing the resources of the family.

11. *Ongoing asylum and sanctuary should be available for that small proportion of the chronically mentally ill who do not respond to current methods of treatment and rehabilitation.* Some patients, even with high-quality treatment and rehabilitation efforts, remain dangerous or gravely disabled. For these patients, there is a pressing need for ongoing asylum in long-term settings, whether in hospitals or in facilities such as California's locked skilled nursing facilities with special programs for the mentally ill.

12. *Research into the causes and treatment of both chronic mental illness and homelessness needs to be expanded.* While our knowledge has greatly advanced in recent years, it is still limited. Treatment of chronic mental illness remains largely palliative, and definitive treatment will occur only with an adequate understanding of etiologic processes. In addition, our understanding of differential therapeutics—that is, what treatment works for which patients in what settings—is in its infancy and requires increased resources and attention.

13. *More accurate epidemiological data need to be gathered and analyzed.* Currently the research findings of incidence of mental illness among homeless groups are highly variable, ranging up to 91 percent; these differences depend largely on such methodological issues as where the sample is taken, whether standardized scales or comparable criteria of illness are used, and theoretical biases. Better data, using recognized diagnostic criteria, need to be acquired.

14. *Finally, additional monies must be expended for longer-term solutions for the homeless mentally ill.* Although health and mental health costs and funding in this country have recently increased, the homeless mentally ill have not been beneficiaries of this increase. Therefore, adequate new monies must be found to finance the system of care we envision, which incorporates supervised living arrangements, assertive case management, and an array of other services. In addition, financial support from existing entitlement programs such as Supplemental Security Income and Medicaid must be ensured.

In summary, the solutions to the problems of the mentally ill homeless are as manifold as the problems they seek to remedy. However, only with comprehensive short- and long-term solutions will the plight of this most neglected population in America be addressed.

Concerns were raised by VA Deputy Chief Medical Director Dr. John Gronvall at the Committee's May 7 hearing that payment for the cost of residential care for only one group of community residential-care participants would adversely impact on the Community Residential Care Program. Concerns were also raised by the APA that sufficient kinds and levels of care and supervision (not normally available in Community Residential Care homes) must be provided for chronically mentally ill veterans in order to make a successful transition into the community.

In response to a question submitted by Chairman Murkowski following the Committee's May 7 hearing, the VA stated:

> Effective treatment of veterans with chronic psychiatric disorders requires a full spectrum of interconnected inpatient, outpatient and community services. This network must have sufficient capacity and flexibility to allow patients, as they are ready, to move from one level of care to the next. Treatment components within this spectrum of care for chronically mentally ill patients include hospital care, domiciliary care, nursing home care, psychiatric transitional community-based residential treatment, community residential care, psychiatric hospital based home care and outpatient psychiatric treatment programs such as mental hygiene clinics, day treatment centers and day hospital programs. These components vary in terms of levels of care, intensity of therapeutic activity and cost. Many of these components are in place in the VA and provide the appropriate level of care for psychiatric patients. We, of course, are looking at various options as to how best to provide the other components.

Committee bill

In response to this testimony and generally to improve the provision, the Committee made certain modifications in the proposed pilot program. Section 102 of the Committee bill would, therefore, provide the Administrator with a discretionary 4-year authority to contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for verterans suffering from service-connected chronic mental illness or veterans who have 50-percent-or-more service connected disabilities and are suffering from chronic mental illness. The Committee believes that this new authority would enable the VA to provide certain service-connected chronically mentally ill veterans with an additional, necessary option for care which is not now but clearly should be provided by the VA to carry out its responsibilities to these service-connected veterans. Of the types of care mentioned by the VA as desirable in treating chronically mentally ill patients, the VA does not currently have the authority to provide psychiatric transitional community-based residential treatment, even for service-connected veterans. Placements in halfway houses or other structured transitional living settings of these chronically mentally ill veterans could produce earlier hospital discharges, fewer readmissions, and decreased use of contract nursing home beds by these

patients. These residential settings would also provide for a level of care between hospitalization or nursing home care and community residential care or independent living. The Committee believes that this program would fill a gap along the continuum of VA care and would make a valuable addition to the VA's options for providing the most appropriate kinds and levels of care to these service-connected chronically mentally ill veterans.

The Committee notes that the VA raised an additional concern about the advisability of the pilot program. The VA stated that its interpretation of the law defining the primary function of the Department of Medicine and Surgery was that it was to provide complete medical and hospital services and not nonmedical social or supportive services. The Committee notes that the VA, during the past 2 years, has strongly urged the Congress to extend the VA's authority to contract for care in halfway houses and other community-based facilities for veterans with alcohol and drug abuse related disabilities. The services provided in the alcohol and drug abuse halfway house program are—as would be those provided under the new authority in the Committee bill—targeted towards helping program participants make a successful transition from institutional services to life in the community.

The Committee does not understand the VA's support for that halfway house program whose function it does not find to be inconsistent with the VA's primary mission while not supporting a similar program to meet the needs of chronically mentally ill veterans. By restructuring the program and modeling it closely after the halfway house program which the VA strongly supports for veterans with alcohol and drug abuse disabilities, the Committee has tried to take into account the VA's views and hopes that the VA will use this new authority for service-connected veterans just as has been done with the similar authority to provide halfway house treatment for veterans with alcohol and drug abuse disabilities.

The Committee notes the support for this new provision by the National Association of VA Chiefs of Psychiatry which agrees with the Committee's view that providing these services as authorized in the Committee bill would be well within the mission of DM&S. An excerpt from a June 11, 1985, letter to Chairman Murkowski from Dr. Arthur L. Arnold, President of the National Association of VA Chiefs of Psychiatry, follows:

> To characterize residential rehabilitation of the chronically mentally ill as nomedical and outside the general statutory mandate of the VA is to confuse this service with a boarding house or fail to recognize the health care nature of VA-operated domiciliaries and community residences and the contract halfway house for alcoholics.
>
> The Association hails this legislative initiative as a much-needed approach to rehabilitation of many of our chronically mentally ill veterans.

The Committee also notes that, according to the VA, 60 percent of the hospitalized psychiatric patients who are potential users of the Community Residential Care Program are non-service-connected veterans who have significant financial problems. Hence, the Committee encourages the VA to assess the needs for care by such

non-service-connected patients of the type that is authorized under this new authority for certain service-connected veterans and to include the results of this assessment in the VA's final report due on April 1, 1990, on the new pilot program.

The Committee further notes that the VA has conducted extensive needs assessments, planning efforts, and program-development to strive to meet the needs of the aging and long-term care patient populations. Efforts such as the 1983 VA-Harvard University conference on long-term care, the 1984 VA-American Health Planning Association conference on long-term care, and the VA's August 1984 report, "Caring for the Older Veteran", have provided the VA, the Congress, and other Federal and private health-care agencies with a substantial body of information with which to assess and plan for the acute and long-term care needs of the aging veteran patient population. The Committee notes, however, that these efforts have not included a specific focus on the long-term-care needs and problems of the VA's psychiatric patient population. In light of the high incidence of psychiatric diagnoses among VA patients, the Committee believes that needs assessments and planning efforts relating to the long-term care needs of veterans suffering from chronic mental illness should be a major priority in the VA's effort to plan for the future direction of its health-care programs.

Pilot Program of Noninstitutional Alternatives to Institutional Care

Section 103 of the Committee bill is derived with modifications from section 9 of S. 6 and section 2 of S. 876. This provision would require the Administrator to conduct a 4-year pilot program, beginning January 1, 1986, and terminating December 31, 1989, at 10 demonstration project sites to provide medical, rehabilitative, and other health services and, by contract, health-related services in noninstitutional settings to certain veterans in order to obviate the need for providing hospital, nursing home, or domiciliary care. Priority in selecting veterans for participation in the program would be accorded to veterans who have service-connected disabilities, to veterans who are 65 years of age or older, and to veterans who are totally and permanently disabled. The total cost of the program would be limited to 60 percent of the cost that would otherwise have been incurred by the VA if the veterans participating in the program had been furnished nursing home care instead of noninstitutional services provided under the program. The Administrator would be required to study the program and to transmit to the Congress, not later than February 1, 1989, an interim report on the study based on the results of the first 36 months of the program's operation. A final report of the pilot program based on the program's 48 months of operation would be submitted not later than April 1, 1990.

Background

During the past several years, considerable attention by the public and private sectors has been focused on the anticipated increase in the number and proportion of persons who will be over 65 years of age in the United States during the next several decades.

Accordingly, efforts have increased to assess the needs, now and in the near future, of the aging population and to plan for and develop programs to meet these needs. A 1984 Census Bureau report, "Demographic and Socioeconomic Aspects of Aging in the United States", estimated that in 1980 there were 25.7 million persons 65 years of age or older, constituting 11.2 percent of the U.S. population; that by the year 2000 the total number of Americans 65 or older is estimated to be 35 million; and that by the year 2030 more than one-fifth of all Americans is expected to be 65 or over.

A December 1984 Department of Health and Human Services (DHHS) report to the Congress and the President, "Health, United States, 1984", stated that in 1980 nearly $21 billion was spent on nursing home care. Approximately 50 percent of the financial support for nursing home patients was provided by Medicaid, 43 percent of those expenditures were out-of-pocket payments, and only about 3 percent of support for nursing home patients was provided by Medicare and private health insurance. In that same year, about 10 percent of the population 75 years of age or over in the United States was institutionalized in nursing homes. The report further stated:

> An important public policy issue about long-term care for the elderly is whether many nursing home residents could receive comparable but less expensive care in noninstitutional settings. Much attention is being given to increasing the accessibility of alternatives to nursing home care such as home health services, congregate housing, and adult day care.

The report also notes that there is a wide range (i.e., 4.2 percent to 16.1 percent) among States in the proportion of elderly persons who are institutionalized and estimates that some of the geographic variation in nursing home use may be related to the availability of alternative forms of care.

During the past decade, Congress has been involved in an examination of Federal policies and programs relating to the provision of home care for the elderly, particularly those under the Medicare and Medicaid programs. Issues relating to eligibility, benefits, reimbursement, the cost and benefits of home care, and the statutory restrictions limiting such coverage under Medicare and Medicaid have been subjects of hearings held by the Senate and House Aging Committees and other committees, reports issued by the General Accounting Office, and legislation initiated by Members of both Houses. A December 1984 report by the House Subcommittee on Health and Long-Term Care of the Aging Committee stated, "The expansion of home care has been supported by liberal and conservative groups, as well as organizations representing the aged."

A major development in this area was the publication by DHHS in March 1985 of regulations permitting States, under the Medicaid program, to cover a broad array of home and community-based services provided to an individual as an alternative to institutionalization, including but not limited to, homemaker services, home health aid services, and personal care services.

VA statistics indicate that in 1980 three million veterans, or 10.5 percent of the total veteran population, were 65 years of age and

over. By 1990, the VA estimates there will be 7.2 million veterans, or 26.6 percent of all veterans, in this age group. In the year 2000, veterans over age 65 will number 9 million or 37 percent of the total veteran population. The VA has been engaged in extensive planning efforts to assess, plan for, and meet the needs of the eligible aging veteran population. The VA's internal planning process, the Medical District Initiated Planning Program (MEDIPP), and other efforts, such as the 1983 VA-Harvard University Conference on Aging and the 1984 VA-American Health Planning Association Conference on "The Complex Cube of Long-Term Care", have been concentrated efforts to exchange information on and plan for the needs, now and in the future, of the aging veteran population. The VA's recent planning efforts culminated in the release of its 1984 report, "Caring for the Older Veteran", which set forth alternatives for the VA to meet the needs of that population. The Committee notes that the VA report also described a number of innovative approaches already underway in the VA for providing long-term care, including programs such as Hospital-Based Home Care, Adult Day Health Care, Geriatric Research, Education and Clinical Centers, and Geriatric Evaluation Units.

An excerpt from the VA's report summarizing four principles central to the VA's strategies for meeting the needs of the elder veteran follows:

AGING: PROCESS, RESULTS AND RESPONSES

Aging is a natural process which occurs in all living things. Every society has developed a complex set of concepts which define its approach to dealing with aging and the aged individual. Even a society as advanced as ours retains many myths concerning aging, myths which ignore the realities of the process. Before society can deal with its aging population, the myths and realities must be clearly recognized, and accounted for in the society's efforts.

The most common myth concerning the aging in this society is that old age is synonymous with illness. Illness is not the unvarying accompaniment of aging. The aging process is accompanied by a gradual decrease in the body's ability to respond to illnesses when they do occur. Aging also increases the susceptibility to certain conditions, particularly those which result from degenerative changes in the body's tissues and organ systems. In the absence of specific illnesses, and with adequate preventive and support services, older individuals can enjoy full and satisfying lives. When illness does occur in older individuals, it may differ in several ways from illness in younger age groups. First, there are certain diseases which tend to occur more frequently in older age groups. These include diseases associated with degenerative changes in tissues and organ systems, particularly cardiovascular diseases, diseases of the bones and joints, and sensory impairment. Second, diseases which are common to other age groups may act differently when they occur in older persons. Their signs and symptoms, clinical course, and response to treatment may be confusing and misleading. Third, some diseases may occur "silently" in older persons, with no specific signs and symptoms, and are only discovered as a result of routine examinations. It is often difficult to draw a line between the changes which reflect the deterioration of function from age and those which represent pathology.

A second myth concerning the aged in our society is that age brings incapacity. In fact, most of the elderly live in the community and in their own households. Only one of every twenty individuals 65 or older in this country lives in a sheltered institution. The remaining 19 live in a household. Older individuals prefer to retain their independence to the maximum extent possible, and maintenance of such independence is widely accepted as the primary goal of programs and services for the elderly. This goal has led to a stress on services in the home, and in other noninstitutional community settings, as the preferable approach to supporting such individuals.

Efforts to maintain health and treat illness are central to meeting this goal, but they are not sufficient by themselves. An effective effort must look to three aspects of the older individual's life situation — financial status, living environment, and system for delivery of health and human services.

The older individual is not, in most cases, equipped to identify, access, and use the range of services, which, if available, can support an acceptable quality of life. This is particularly true for the individual who has one or more chronic health problems, whose financial resources are marginal, or who has no family support systems available. Accordingly, a fourth element is required in a system for dealing effectively with the older person, a service management or coordination element.

In the larger society, each of these required components — services, facilities, and living conditions — has evolved independently, as have coordination efforts. In the VA, all the required elements exist within the Agency. Coordination is no less important, but presents fewer problems than it does in the private sector.

Reflecting these factors, there are four objectives which should characterize any effort to develop and carry out an effective program:

- To sustain older individuals' independence, comfort and contentment in their own home environment for as long as possible, providing supportive services required to do so.
- To provide those who, because of infirmity, lack of a proper home or other circumstances, need additional care and attention with residential accommodations.
- To provide backup hospital accommodations offering skilled medical or nursing care during episodes of illness requiring such care.
- To assure that each older individual's needs are assessed fully, and that services required are appropriately coordinated.

These principles are central to the VA's strategies for meeting the needs of the older veteran.

The Committee notes that the first objective which the VA states should characterize any effort to develop and carry out an effective program is "to sustain older individuals' independence, comfort and contentment in their own home environment for as long as possible, providing supportive services required to do so."

Committee bill

S. 6 would have required the Administrator, in order to evaluate the effectiveness, feasibility, and desirability of various actions that would enable veterans to receive needed care in noninstitutional settings, to carry out a 4-year pilot program in five geographic regions, during which veterans participating in this program would receive coordinated services, both a wide variety of health-care services from the VA and health-related services under certain circumstances from appropriate public and private agencies that provide such services. Eligibility for the program would have been based on veterans' eligibility for hospital or nursing home care and the need for such care or for ambulatory care to obviate the need for such institutional care. Priority would have been given to veterans with service-connected disabilities, to veterans who are 65 or older, and to veterans who are permanently and totally disabled.

S. 876 would have required the Administrator to establish and conduct a 3-year pilot program in five geographic areas to furnish medical, rehabilitative, and social services, which would obviate the need for nursing home care, to certain veterans. Veterans would have been eligible to participate in the program if, first, they were eligible to receive VA nursing home care; second, without receiving the services provided in the program they would receive nursing home care; and, third, as a result of receiving the services provided in the program they would be able to reside at home in a substantially self-sufficient manner. The Administrator would have been required to give priority to veterans over 65 years of age and to veterans who are catastrophically disabled. The cost of carrying out the program in any fiscal year would not exceed 60 percent of the cost that the VA would have incurred if the VA had otherwise provided the veterans participating in the program with community nursing home care.

VA testimony provided at the Committee's May 7 hearing stated, "VA favors the basic concept of developing alternatives to institutional care." The VA also noted that draft legislation formally submitted to the Congress by the Veterans' Administration on March 27, 1985, has been developed to authorize the VA to conduct a 3-year pilot test of "respite care". The Committee notes, however, that this proposed program would address the needs only of those veterans already residing at home. The program provided for in the Committee bill is designed to address the needs of those veterans who are not yet receiving health-related services in the home, who may be at risk of being institutionalized due to an absence of such services, or who may already be in a VA hospital or nursing home but could reside in the community with the support of appropriate health-related services.

The Committee also notes the VA's general concern that the VA's mission is to provide veterans with medical services and that the VA's mandate generally excludes the provision of nonmedical

social or supportive services, as part of certain existing VA programs, nonmedical social or supportive services. The care provided as part of VA domiciliary care, contract nursing home care, and halfway house care for veterans with alcohol and drug abuse disabilities includes components which are nonmedical social or supportive services.

The Committee bill would require that the VA include, as part of its study on the pilot program, the results of an assessment of the needs of veterans for health and health-related alternatives to noninstitutional care. The Committee expects the VA, with a focus on veterans with chronic long-term care needs, to assess the need for a full spectrum of health-related and social services to assist veterans to remain outside of institutional long-term care settings. The Committee also intends that the VA examine the capacity in the non-VA public and private sectors to provide such services to VA beneficiaries now and over the next 20 years.

The Committee notes that the Committee bill would provide the VA with the flexibility to determine the most appropriate program sites, but the Committee intends that the VA select sites which vary in location and are geographically dispersed and ensure that each VA Region has at least one such site. The Committee also believes it is important for the VA to consider the needs of veterans residing in rural areas when selecting the sites.

Finally, the Committee points out that under the Committee bill the VA would not be given any new authority to furnish health-related services directly. Rather, the health-related services for which VA is authorized to contract under the Committee bill would include services such as home health aid services, personal care services, homemaker services, nutrition services, and transportation assistance.

Chiropractic Care

Section 104 of the Committee bill, which is derived from S. 1052, would amend title 38 to require the Administrator of Veterans' Affairs to conduct a 3-year pilot program, beginning January 1, 1986, and terminating December 31, 1988, of not less than one demonstration project in each of five geographic regions of the United States for the purposes of furnishing certain chiropractic services to eligible veterans and evaluating the therapeutic benefits and the cost-effectiveness of such services.

Background

In virtually all other areas of the Federal health-care delivery system, Congress has recognized the role of chiropractic care. Moreover, a number of States also include chiropractic services under their medical assistance programs.

The chiropractic patient population today in the United States is estimated to be between 10 and 20 million. The provision of chiropractic services is authorized for eligible persons under the Medicare and Medicaid programs. Chiropractic services are provided to Federal employees under several health plans offered through the Federal Employee Health Benefit Program. Federal employees have chiropractic coverage under the Federal Employee Workers'

Compensation Program for work-related conditions. Authorization for chiropractic health services is included in the Railroad Retirement Act. Last year, with the enactment of section 632(b) of the Department of Defense Authorization Act of 1985, Public Law 98-525, Congress authorized the Secretary of Defense to conduct demonstration projects for the purpose of evaluating the cost-effectiveness of chiropractic services under the CHAMPUS program.

The Veterans' Administration has the general authority to provide chiropractic services directly through chiropractors whom it may employ, as pat of furnishing hospital care as defined in section 601(5)(A)(i) of title 38 and medical services as defined in section 601(6) of title 38, to any veteran eligible to receive such care or services who is in need of chiropractic services. However, the VA to date has chosen not to use this authority. Moreover, the VA has the general authority to provide such chiropractic services on a contract basis under the general criteria prescribed in section 601(4)(C) of title 38 for the provision of care and treatment on a contract basis—that is, when VA facilities are not capable of furnishing economical care because of geographic inaccessibility or because the service is not available at the VA facility in question. However, despite this authority, few veterans have been referred to private chiropractic practitioners by VA physicians.

Committee bill

Since the VA continues to maintain its previous position of not utilizing existing authorities to provide, on a demonstration project basis, chiropractic services in appropriate cases as part of the hospital care or medical services furnished to veterans, the Committee has included in section 104 provisions to require a 3-year pilot program under which the VA would pay for the furnishing of certain chiropractic services to certain eligible veterans and evaluate the results of doing so. The pilot program would be conducted during the period beginning January 1, 1986, and ending December 31, 1988. The Committee bill would authorize reimbursement (or direct payment) for the reasonable charges, within certain prescribed limitations, for certain chiropractic services furnished certain eligible veterans.

Specifically, section 104 of the Committee bill would require the Administrator, under regulations the Administrator would prescribe, to reimburse veterans eligible for medical services under chapter 17 of title 38, United States Code, for the reasonable charge for chiropractic services for which a veteran has made payment, or to make direct payment to a chiropractor for such services, if such services were for (1) the treatment of a service-connected neuromusculoskeletal condition of the spine, or (2) the veteran has been furnished hospital care by the VA for a neuromusculoskeletal condition of the spine within a 12-month period prior to the provision of chiropractic services, or (3) the veteran has a 50-percent or greater service-connected disability and has been furnished hospital care or medical services by the VA for a neuromusculoskeletal condition of the spine. Such reimbursement would be provided only to the extent that the veteran is not entitled to such chiropractic services or reimbursement or payment for the expenses of such services under health insurance or others form of

third party health-care coverage. Thus, under the Committee bill, the veteran must have been determined by the VA to have a neuromusculoskeletal condition of the spine. In all likelihood, the veteran would have been given an x-ray examination by the VA at some time prior to such veteran being eligible for reimbursement or payment for chiropractic services under the proposed Committee provisions.

In determining the reasonable charge for chiropractic services, the Administrator would be required to consult with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services (such as the Social Security Administration in the Department of Health and Human Services and the Office of Workers' Compensation Programs in the Department of Labor), and then to establish a schedule of reasonable charges similar to those allowed under section 1842 of the Social Security Act (42 U.S.C. 1395u). Annual reimbursement or payments on behalf of an individual veteran would be limited to $600. Total expenditures in any fiscal year for chiropractic services under the demonstration projects could not exceed $2 million.

In designing the demonstration projects to provide chiropractic services for eligible veterans, the Committee bill would require the Administrator to consult with the Secretary of Defense regarding the demonstration projects to provide chiropractic services carried out by the Secretary of Defense under section 632(b) of the Department of Defense Authorization Act, 1985 (10 U.S.C. 1092 note). During the process of designing and conducting, the demonstration projects and evaluating the results, it is the intention of the Committee that the Administrator solicit advice and recommendations from recognized medical and scientific authorities in the treatment of neuromusculoskeletal conditions, including doctors of chiropractic and chiropractic academicians recognized by an approved accrediting organization.

Also, under the Committee bill, the term "chiropractic services" would be defined, in a new paragraph (9) which would be added to section 601 of title 38, as "the manual manipulation of the spine performed by a chiropractor (who is licensed as such by the State in which he or she performs such services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5)) to correct a subluxation of the spine." This term would not include "physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded." This section would, therefore, limit the chiropractic services which the VA is authorized to provide directly (should it choose to do so) or by contract under certain circumstances (as well as under the demonstration projects) to spinal manipulation as treatment for a neuromusculoskeletal condition. When provided on a fee-basis, these chiropractic services would be authorized to be provided in private facilities or chiropractic colleges to the same extent as authorized under Medicare.

In its testimony on May 7, the VA voiced opposition to legislation authorizing demonstration projects to provide chiropractic services, stating that "disorders of the musculoskeletal system are

skillfully and appropriately treated in the VA by physicians, medical and surgical subspecialists, and specialized support personnel." The Committee disagrees with the VA's position that it should not provide chiropractic services. The Committee believes that chiropractic services for the treatment of musculoskeletal conditions of the spine may be beneficial in some cases. In authorizing demonstration projects to provide chiropractic services, it is the goal of the Committee to obtain information to assist in determining cost-effective alternatives to medical treatment.

Finally, to enable the Committee to make an informed judgment as to the need for any further legislation after the proposed statutory termination date of December 31, 1988, the Committee bill would require the Administrator to submit to the Senate and House Committees on Veterans' Affairs, not later than April 1 of each of the years 1987, 1988, and 1989, an annual report regarding the utilization of chiropractic services under the new pilot program authority.

TITLE II—EXTENSION OF AUTHORITIES AND ELIGIBILITIES

Definition of Vietnam Era

Section 201 of the Committee bill, which is derived from section 2 of S. 6, would modify the definition of the Vietnam era in section 101(29) of title 38, United States Code—the overall title 38 definition of the Vietnam era for the purpose of certain veterans' benefits—to include, in the case of those who served in the Republic of Vietnam, the period beginning with February 28, 1961, the date established in Public Law 89-257 for acceptance for foreign awards for service in Vietnam and used in a variety of other contexts (described below) as a starting date for the Vietnam conflict, and ending on May 7, 1975, the current law ending date for the Vietnam era.

Background

An identical provision was reported by the Committee during the last Congress as section 8 of S. 2514 and passed by the Senate on August 9, 1984, as part of H.R. 5618. However, that provision was not included in the compromise agreement reached with the House of Representatives on that legislation and enacted as Public Law 98-528.

As noted above, the starting date for the Vietnam era in current law is August 5, 1964. This date coincides with the Gulf of Tonkin incident and the approximate date of adoption of the resolution by the Congress following that incident. (The action leading to this Congressional action—the reported attack by North Vietnamese gunboats on two U.S. Navy destroyers—occurred on August 4; on August 5, President Johnson sent a message to the Congress regarding the matter and a joint resolution was introduced in Congress response thereto; on August 7, the Congress approved the so-called "Gulf of Tonkin Resolution" which was signed into law as Public Law 88-408 on August 11, 1964.)

However, after careful consideration, the Committee determined that February 28, 1961, is a more appropriate starting date for the

title 38 definition for those who served in Vietnam. This is the date set forth in Public Law 89-257 after which U.S. service personnel could accept awards from the Government of the Republic of Vietnam in connection with service in Vietnam. In the reports on the legislation—H.R. 3045 in the 89th Congress—that led to this public law, the Committees on Armed Services in both the House of Representatives and the Senate indicated that this date was selected because that was the approximate date on which American military advisers began to accompany "their Vietnamese counterparts on military operations" (H. Rept. No. 89-239, p. 2; S. Rept. No. 89-800, p. 2). This same date is used in other statutory contexts, including in section 112 of the Internal Revenue Code (relating to the treatment of income for tax purposes for members of the Armed Forces serving in Vietnam in certain circumstances) and in section 239(a) of the Immigration and Nationality Act (INA) (section 1440 of title 8, United States Code, relating to expedited naturalization based on wartime service). In addition, as noted in a letter from a Department of Defense representative to the Chairman of the House Committee on the Judiciary in connection with that committee's consideration in 1966 of the proposed amendment to the INA (which was enacted, as noted above), February 28, 1961, is the date selected by the Department of the Army for the award of the Combat Infantryman's Badge and the Combat Medical Badge.

Committee bill

In considering the issue of the appropriate starting date for the Vietnam era, the Committee recognized that there were a number of practical difficulties in setting a fixed date for a period of hostilities, such as were involved in Vietnam, where there was no one date when the United States' involvement changed in a dramatic fashion. The Committee believes that bringing the starting date of the Vietnam era for title 38 purposes into conformity with the above provisions for those who actually served in Vietnam, as is proposed in the Committee bill, would be an appropriate action that would make access to veterans' benefits on the basis of service in Vietnam during wartime more consistent with other laws and regulations relating to such service.

The Committee notes that two other provisions in title 38 which define periods of war—section 101(6) (Spanish-American War) and section 101(7) (World War I)—are precedents for the approach adopted in the Committee bill for the definition of the Vietnam era. In both of those provisions, the period is longer for those who served in particular locations during specified periods.

The VA, which testified in support of this provision at the Committee's May 7, 1985, hearing estimated that "approximately 48,000 veterans served in Vietnam between February 21, 1961, . . . and August 5, 1964". It is not known, however, how many of these individuals served earlier during the Korean conflict or later during the Vietnam era and are, therefore, already veterans of a period of war. The veterans' benefits that individuals who served in Vietnam during the period from February 28, 1961, to August 4, 1964 (the current starting date for the Vietnam era) but not any other period of war might receive as a result of the enactment of this provision include non-service-connected pension benefits if they also meet

disability (or age), income, and net worth limitations; readjustment counseling; certain burial benefits; loan guaranty benefits in certain cases; and certain employment benefits.

Extension of Health-Care Eligibility Based on Exposure to Dioxin or Other Toxic Substances in Vietnam or to Nuclear Radiation

Section 202 of the Committee bill, which is derived from section 4 of S. 6, would extend until September 30, 1989, the provision in current law which provides certain veterans—those who exposed to dioxin or other toxic substances used in herbicides or defoliants in Vietnam or to ionizing radiation from nuclear detonations—with eligibility for priority health care from the VA for the treatment of most disabilities.

Background

Under current law, this authority, which was enacted in 1981 by Public Law 97-72, is scheduled to terminate 1 year after the Administrator submits the first report on the epidemiological study of Vietnam veterans mandated by Public Law 96-151. That report is to be submitted 24 months after the protocol for the study is approved, which occurred on February 14, 1985. Thus, this special, interim health-care eligibility is scheduled to expire on February 14, 1987.

Committee bill

The Committee is proposing to extend this authority because the major study designed to yield the necessary information—the epidemiological study of Vietnam veterans mandated in 1979 by Public Law 96-151 and authorized to be expanded by Public Law 97-72, which is being carried out by the Centers for Disease Control (CDC), and any scientific study of the health status of veterans exposed to radiation undertaken pursuant to Public Law 98-160—will not be sufficiently advanced by February 1987 to permit final decisions to be made at that time.

The CDC study—which is now underway—will involve 30,000 veterans, 10,000 of whom will undergo comprehensive 3-day medical examinations at a nongovernmental medical facility in Albuquerque, New Mexico. The scope of this investigation—the costs of which, together with a Selected Cancers Study, will be $75 million—is unprecedented among major epidemiological studies, especially inasmuch as it includes such a larger number of actual medical exams. However, no results regarding the health effects of exposure to dioxin are expected prior to September 1988, the target date that CDC has set for reporting on the study. If that target date is met and this extension has been enacted, the Congress would have a year before the proposed new expiration date in which to evaluate the results of the CDC study and other pertinent information and make decisions on appropriate further action with regard to dioxin exposure.

The Committee intends to monitor closely the CDC study and other ongoing studies relating to dioxin exposure as well as studies and other activities relating to the health effects of exposure to radiation. It is the Committee's intention to reconsider the need for

this health-care authority if, at any time between now and September 1989, new, sound scientific data regarding the health effects of dioxin or radiation exposure are developed.

The VA at the May 7 hearing supported the extension of this authority.

Counseling for Former Prisoners of War

Section 203 of the Committee bill, which is derived from a provision authored by Senator Denton, would provide the VA with the authority to establish a program under which, upon the request of a former prisoner of war, the VA would, within the limits of VA facilities, furnish counseling to such a veteran to assist such veteran in overcoming the psychological effects of detention or internment as a prisoner of war.

Background

Public Law 97-37, the Former Prisoner of War Benefits Act of 1981 enacted on August 14, 1981, included several provisions which are designed to address the specific needs of former prisoners of war (POW's). Among other things, Public Law 97-37 established an Advisory Committee on Former POW's, reduced from 6 months to 30 days the minimum period of internment required for application of the presumptions that certain disabilities of POW's are service-connected, eliminated the requirement that in order to be presumed service-connected a psychosis of a former POW must be manifest within 2 years after discharge from active duty, added the anxiety states to the list of disorders presumed to be service-connected, provided former POW's with eligibility for VA hospital and nursing home care and outpatient treatment, and placed non-service-connected former POW's in a priority category for outpatient care ahead of all other non-service-connected veterans.

Since 1981, the Committee has carefully monitored the VA's efforts to implement Public Law 97-37 and has continued to communicate regularly with the VA on its efforts to comply with the spirit and intent of the law. One specific area of concern, the relationship between the POW experience and depression, was addressed in testimony presented at the Committee's April 11, 1983, hearing as well as the the June 1983, report of the Advisory Committee on Former Prisoners of War.

The Advisory Committee's report stated:

> The extreme hardships, deprivation, abuse, stress and prolonged life-threatening experiences to which the POW was exposed are recognized to have engendered a deep and abiding inner rage, which, when unexpressed or unresolved, is fertile soil for the growth of depression.

Public Law 98-223, the Veterans' Compensation and Program Improvements Amendments of 1984, which was enacted on March 2, 1984, added dysthymic disorder (or depressive neurosis) to the list of diseases presumed to be service-connected for former POW's. The addition was meant to give full effect to the intent of the Congress underlying Public Law 97-37's addition to anxiety states to the list.

Committee bill

The Advisory Committee on Former POW's states that as of January 1, 1985, the total number of living former POW's is 85,987. The largest number, 81,347, are from World War II; 3,618 are from Korea; 620 are from Vietnam; and 402 are from World War I.

At the Committee's June 12, 1985, meeting Senator Denton, in his introductory remarks summarized the need for this provision:

> Many POW's from WWII and Korea have had no place to go to receive counseling or to talk about their experiences with a professional trained to deal with those matters. The current law requires that a former POW must have a disability in order to be eligible for treatment. I know from personal experience, however, that a former POW does not necessarily have to have a certified disability in order to experience trauma from the ordeal of imprisonment and mistreatment. I know that there are many former POWs who have not even talked about their World War II POW experience since the war ended in 1945, in large part because there was no trained individual available to listen. I believe that the amendment will solve their problem.

The Committee bill would provide the VA with the discretionary authority to establish a program to provide counseling to former POW's within the limits of VA facilities. The purpose of the counseling would be to assist former POW's in overcoming any psychological effects of their internment. Under section 612A of title 38, the VA currently provides such psychological counseling to former POW's who are also Vietnam-era veterans and who request readjustment counseling. However, those former POW's of other eras who have not been diagnosed as having specific psychological disability are not eligible for such outpatient counseling services.

In light of the significant number of former POW's (85,987) and the fact that only 620 have access, under section 612A, to counseling specifically tailored to the needs of veterans who have experienced combat-related trauma, the Committee believes that a specific authority in this area is necessary. With the new authority, the VA would be able to counsel on an outpatient basis former POW's who request such counseling. The VA would be authorized to establish programs specifically tailored to meet the special needs of former POW's. The Committee encourages the VA to examine and develop innovative programs and methods of counseling, taking into account existing methods before implementing any new counseling programs, and to structure the program so as to encourage former POW's who feel the need for counseling assistance to seek it from the VA.

The Committee notes that under section 240 of title 38, United States Code, the VA has an alternative outreach obligation to advise veterans of VA benefits. Therefore, if the Administrator elects to exercise the authority to establish this new program of counseling, the VA will have the obligation, to the maximum extent practicable, to develop nationwide outreach to notify former POW's of the availability of such counseling programs. In that event, the Committee expects the VA to work with the Former

POW Advisory Committee to ensure that former POW's are made aware of their new eligibility.

Alcohol and Drug Abuse Treatment and Rehabilitation

Section 204 of the Committee bill, which is derived from section 5 of S. 6 and section 3 of S. 876, would extend for 3 years, through September 30, 1988, the VA's present discretionary authority to contract with halfway houses and other community-based facilities for the treatment and rehabilitation of veterans with alcohol or drug abuse or dependence disabilities and would require the Administrator to submit to Congress, by February 1, 1988, a report on the cost-effectiveness and success of the program. It would also delete the references in current law to this program being a "pilot" program. This would be the first extension of this authority.

Background

Public Law 96-22, the Veterans' Health Care Amendments of 1979, established a 5-year pilot program for the treatment and rehabilitation of veterans with alcohol or drug dependence of abuse disabilities. Under this pilot program, the VA was provided with specific authority to contract with halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for alcohol and drug treatment and rehabilitation for veterans. Public Law 96-22 also required the Administrator to report to Congress, by March 31, 1983, on the effectiveness of this pilot program; the due date of the report was subsequently postponed to March 1, 1984, by section 6 of Public Law 97-251. The VA submitted the report to the Congress on May 1, 1984.

Section 3 of S. 2514, as approved by the Committee on May 9, of last year, as passed by the Senate on August 9, 1984, would have extended for 2 years, through September 30, 1987, the VA's authority to contract with halfway houses and other programs and required the Administrator to report to Congress, not later than March 1, 1986, on the operation of the program. This provision extending the program was not included in the final compromise legislation (H.R. 5618) agreed to with the House.

VA 1984 report

On May 1, 1984, Administrator of Veterans' Affairs Harry Walters, in submitting the VA's report on the contract program, stated, "Our evaluation of this pilot program shows that it provides an important option for treatment of certain cases of substance abuse which require care beyond existing VA hospital alcohol and drug unit capabilities." The administration recommended that the contract authority be extended for 3 years. The VA's review of the program included an examination of the status of the program participants 9 months following discharge from initial inpatient treatment. The VA found:

1. At the time of 9 months followup, 67.4 percent of those veterans who had completed the contracted residential treatment program were found to be abstaining from any use of alcoholic beverages. Of those who had dropped out of such con-

tracted care prior to completion of treatment, 60.5 percent were maintaining sobriety.

2. At 9 months followup, 63 percent of the veterans who had completed the contracted treatment program, were still actively participating in Alcoholics Anonymous (AA) meetings. Of those who had dropped out of the contract program at some point prior to completing treatment, 50.8 percent of that group were still actively participating in Alcoholics Anonymous (AA).

3. The presence of significant other persons, (i.e., available family) in the life of the patients was found to be associated with higher rates of abstinence. At the 9 months followup of those who had completed care at the contracted community program, 70.5 percent of those who had a significant other person in their lives (with potential for positive reinforcement) had attained sobriety, whereas 57.8 percent of those who lacked a significant other person in their lives, had attained sobriety.

4. In the cases of all three patient groups (i.e., those who completed contracted rehabilitation programs, those who participated but did not complete the contracted rehabilitation, and those who declined the outplacement and continued in VA provided treatment), 60 percent or more of the patients had established personal sobriety.

5. The awesome, destructive impact of alcohol abuse on marriage was demonstrated in this group of incapacitated veterans, who were assessed to be in need of transitional residential support, i.e., contracted rehabilitation. At the time of initial VA admission, only 5.5 percent of those later outplaced were married; at 9 months followup after treatment began, 11.1 percent were married. Of the 722 patients recommended for outplacement into extended residential care 72.4 percent were divorced or separated at the time of VA admission. These data compare to survey data on the total population of veterans admitted to VA programs for alcoholism, wherein 31.2 percent of that population were married at time of VA admission.

6. During the 9 months following VA admission, fewer repeat detoxifications were required for the group of patients who completed the contract program. Their mean number of detoxifications was 1.2, 33 percent less frequent than the mean of 1.6 reported for the other two groups of patients.

7. At the time of VA admission, 30 percent of the veterans were employed on a full-time basis. At the 9 months followup, 48.4 percent of those who had completed the contracted community program were employed full time, a 61-percent improvement; 40.5 percent of those who had rejected the contracted program placement were employed full time, a 35 percent improvement; and 28.5 percent of those who had begun the contracted rehabilitation program but had left it before completion, were employed full time, a 5-percent decrease in full-time employment.

8. Income earned from full-time employment increased for all three groups of patients. For those who completed the contracted rehabilitation program, the increase in income was 71.2 percent; for those who rejected the contract placement, the in-

crease in income was 26.6 percent; for those who accepted and began the contracted care and rehabilitation, but left the program before its completion, the increase in income was 11.1 percent.

9. Comparison of the medical and social costs incurred prior to VA admission and prior to followup, utilizing comparable periods, indicates the net effect was a decrease in costs incurred by the study group of patients who completed the contracted community program, and increasing costs for the other two groups.

10. Of the study group of patients who completed the contracted program care, 16.2 percent were readmitted to VA inpatient alcoholism treatment. Of the group who began but left the contracted program before its completion, 21.2 percent were readmitted for VA treatment during the followup period. Of the group which was recommended but rejected contracted program care, 17.3 percent were readmitted for VA inpatient treatment. This latter group, however, averaged 5.2 weeks of additional inpatient treatment versus a 3.5-week average for those who had participated in a contracted community program.

11. A review of costs across the 9-month followup period following discharge from initial VA inpatient treatment, indicates that $1,289 was spent subsequently per patient who entered and completed contracted halfway house services, for repeated detoxification, for subsequent readmissions to VA inpatient or, to non-VA inpatient or outpatient treatment programs; $2,037 was expended for such relapse-related services, per patient who entered and left prematurely from the contracted community rehabilitation program; $1,635 was expended for such relapse-related services, per patient who was recommended for but rejected the outplacement into the non-VA community-based program. The modest initial cost of contracted community-based care was quickly followed by improved health, adjustment, and decreasing medical and social costs.

Section 3 of S. 2514, as approved by the Committee on May 9, of last year, and as passed by the Senate on August 9, 1984, would have extended for 2 years, through September 30, 1987, the VA's authority to contract with halfway houses and other programs and required the Administrator to report to Congress, not later than March 1, 1986, on the operation of the program. This provision extending the program was not included in the final compromise legislation (H.R. 5618) agreed to with the House.

The VA Inspector General (IG) conducted an audit on the contract program for veterans suffering from alcohol or drug dependence "to determine the adequacy of internal controls over payments made for alcohol and drug rehabilitation services" under the program. In a November 20, 1984, report on the audit, the IG found that VA medical centers participating in the pilot program increased from 13 in 1980 to 79 in 1983 and costs of contracts for the same period increased from $46,452 to $4.7 million. The VA referred 4,995 veterans to contract facilities in fiscal year 1983.

The IG further summarized the findings of the report as follows:

> We found that management attention is needed in several areas. As a result of inadequate authorization and placement practices, there was little assurance that veterans would benefit from placement in about 42 percent of the cases reviewed. We estimate that VA-wide payments for these cases would be about $2.4 million. Also additional guidance and monitoring is needed to ensure that contractors provide the services required by VA policy and to reduce overbillings.

The IG further reported that the Acting Chief Medical Director had agreed to revise program guidelines and policies, and concluded that implementation of the revision should provide effective monitoring and control over contractor services and billings.

Committee bill

In testimony provided at the Committee's May 7, 1985, hearing, Dr. John Gronvall, Deputy Chief Medical Director, strongly supported a 3-year extension of VA's authority to operate this program, as proposed in section 5 of S. 6, but did not support making the authority permanent as proposed in section 3 of S. 876 as introduced. Dr. Gronvall indicated that approximately 6 to 8 percent of VA substance dependence or abuse patients are "alienated from society" and lack family support and employment. The VA has found that the peer setting, residential support, and focus on self-help and job skills is more successful than VA hospital care in successfully helping this 6 to 8 percent of VA substance abuse patients, particularly the recovery-resistant cases, to reenter the community. The VA also concluded that the lower costs of residential care shortens the total VA hospital bed days. As of the end of fiscal year 1984, 83 VA medical centers had contracts with 297 non-VA community-based programs, and 16,685 veterans had been outplaced for such treatment for a total program cost of $6.1 million for fiscal year 1984.

Testimony received at the hearing from The American Legion, the Veterans of Foreign Wars, and the Paralyzed Veterans of America also supported a 3-year extension of the program authority.

In light of the recommendations of the VA and the veterans' service organizations, the Committee determined it to be more appropriate at this time to extend, for an additional 3 years, the VA's authority to provide such services on a contract basis while changing the program from a pilot program to a permanent one.

Due to the continued program growth and the IG's recommendations for improved program controls, the Committee also determined that it would be appropriate to require the Administrator to monitor the effectiveness and the costs of the program and submit, not later than February 1, 1988, a report to Congress on his findings. The report would include data on the use of and cost of the program.

TITLE III—HEALTH-CARE MANAGEMENT

Veterans' Administration Employee Grade Reduction

Section 301 of the Committee bill, which is derived from section 3 of S. 6, requires the Administrator to submit to the Committees on Veterans' Affairs of the Senate and the House a report prior to implementing any systematic reduction in the number of VA employees at any specific grade level in certain employee categories. The bill also would prohibit grade reductions in other categories of employees that are disproportionately greater than any Government-wide reductions at the same grade level.

Background

On July 27, 1984, the Office of Personnel Management (OPM) initiated a program to reduce the proportion of positions in the Federal workforce at grades GS/GM 11-15 (hereinafter referred to as "GS 11-15"). This program is an effort to respond to a finding of the President's Private Sector Survey on Cost Control (the Grace Commission) that there are a disproportionate number of Federal civil service employees in grades GS 11-15 as compared to the number of employees at comparable salary levels in the private sector. The Grace Commission found that the Federal Government has 50 percent more of its workforce at high grades than in the private sector. In addition, Federal workforce statistics indicated that the proportion of the Federal workforce in grades GS 11-15 has been steadily increasing. In 1959, 21 percent of the General Schedule full-time workforce was in the GS 11-15 band. By 1983, the proportion had increased to 39 percent.

Information available to the Committee indicates that the VA position management and position classification programs compare favorably to others in government and that the VA has an aggressive personnel management evaluation program. The Grace Commission reported that approximately 26 percent of white collar employees in the private sector earn salaries equivalent to the GS 11-15 range. For the VA, the figures are: Overall VA—24.3 percent, overall DM&S—23.1 percent, DM&S title 5 employees—13.9 percent, and DM&S title 38 employees—50.8 percent.

The administration opposed this provision on the basis that "any steps to control grade levels . . . should be accomplished *within* an executive agency and not be conditioned upon any report to the Committees of the Congress." In addition, the VA's submitted testimony stated the view that "the definition of a grade reduction [in S. 6] . . . [was] "overboard" and that it could apply to "any systematic action which would result in grade reductions." As is discussed in more detail below, the Committee bill limits the advance-reporting requirement to approximately 55 percent of the GS 11-15 positions in the agency at those grades and is not intended to prohibit the VA from proceeding with routine downgrading efforts which are not designed to reduce salary levels without reference to job responsibilities.

Committee bill

The Committee bill would prohibit the implementation of a systematic grade-reduction effort with respect to VA personnel providing patient-care services or services incigent to patient care or serving in the capacity of attorneys or engineers unless the Administrator has first submitted a report (with specified contents) on the proposed reduction to the two Committees on Veterans' Affairs. This report would have to be submitted at least 90 days in advance of the proposed implementation (not counting any day on which either House is not in session), and would be required to contain a detailed plan for the grade reduction along with a detailed justification for the reduction, including the Administrator's determination, together with supporting data, that, in the personnel area concerned, the VA is overgraded in comparison to non-VA entities. This provision does not prohibit the VA from implementing such a grade reduction subsequent to submitting the required report to both Committees.

As a check on this process, the Comptroller General would be required to submit to the Committees, not later than 45 days after the Administrator submits a report, a report on the Administrator's compliance with these requirements and on the accuracy of the Administrator's determination and supporting data.

As introduced, the provision in S. 6 relating to grade reductions would have applied to all VA employees. According to VA figures, the total number of VA employees in grades GS 11-15—the group being targeted in the current grade reduction effort—is almost 22,000. The provision in the Committee bill was modified as described above to apply only to certain health-care personnel and professional employees serving as engineers and attorneys. The change results in approximately 12,000 employees (10,500 direct and indirect health-care personnel, 550 attorneys, and 900 engineers) in grades GS 11-15 being covered by the proposed advance-reporting requirement.

The Committee believes that these covered categories are the major ones where the VA is forced to pay high entry-level salaries in order to recruit and retain the professional personnel it requires to serve veterans. For example, the Committee is concerned about the possible impact of the pending grade-reduction program on VA psychologists and social workers who are the primary clinical staff for specialized Post-Traumatic-Stress Disorder units for Vietnam veterans in certain VA medical centers and for Vet Centers providing readjustment counseling services to Vietnam-era veterans. The Committee is aware, however, that there may be other categories of employees as to which the competitive entry-level salary would be at or near the GS-11 rate—for example, architects (92 employees), auditors (122 employees), and accountants (170 employees)—who, it might be argued, should be included in this provision. For these reasons the Committee intends to study carefully the justification for any grade reduction activities regarding these and other employees and the need for further legislation in the area.

With further reference to those VA employees not specified in the proposed advance-reporting provisions, the Committee bell includes a provision which prohibits the Administrator from imple-

menting a systematic grade reduction effort that would result in those non-specified employees at a particular grade level suffering a grade reduction at a rate greater than Government-wide reduction rate for that grade, that is, the rate of reduction in that grade for all other Federal agencies and departments combined. Thus, for example, if the total number of non-VA Federal employees in grade GS–13 were being reduced Government-wide by 2 percent in a given fiscal year, no systematic effort to reduce non-specified VA employees (that is, other than direct and indirect health-care personnel, lawyers, and engineers) in grade GS–13 by more than 2 percent would be permitted by virtue of this provision. This prohibition is designed to guard against a disproportionate reduction being applied to some employees in an effort to have the VA nevertheless achieve the overall agency reduction that could have been achieved but for the agency electing not to reduce any group covered by the advance-reporting requirement.

This limitation would not prohibit the VA, however, from proceeding with a downgrading effort designed to correct a clear example of overgrading in a particular occupational category as demonstrated by an evaluation of job responsibilities carried out by the VA in accordance with standard personnel practices. This would be so even if other Federal agencies were downgrading the same occupation and the VA's downgrading affected a greater percentage of the workers in the GS 11–15 series. This is because such a downgrading would not be, in the words of the bill, "for the purpose of reducing average salary costs"; rather, it would be for the purpose of properly categorizing and compensating functions carried out by certain occupations.

Finally, the Committee notes that neither the proposed advance-reporting requirement nor the limitation against disproportionate VA reductions would be applicable at all to standard personnel management activities aimed at protecting against overgrading—such as individual desk audits to determine if a particular job is overgraded—so long as those activities are not carried out as part of a systematic Government-wide effort to achieve grade reductions pursuant to some arbitrary formula.

Medical Quality-Assurance Records

Section 302 of the Committee bill, which is derived principally from section 7 of S. 6 and, in part, from section 5 of S. 876, would amend section 3305 of title 38, to make clear that that provision of law, which makes confidential certain VA records created by the VA through the agency's medical quality-assurance program, does not preclude the release of aggregate data relating to morbidity and mortality associated with various VA programs. The only such aggregate data that would continue to be kept confidential would be data which explicitly or implicitly identify an individual VA patient or employee or an individual involved in a quality-assurance activity.

Background

Under the VA's medical quality-assurance program, known as HSRO (Health Services Review Organization) (38 C.F.R. § 17.500 et

seq.), VA medical professionals review the health-care activities in a facility to determine if any deficiencies exist in such care and, if so, recommend corrective action. The program is divided into two main components: An external review process, the Systematic External Review Program (SERP), involving teams composed of VA health-care professionals from outside a particular VA facility who conduct a comprehensive review of all facets of the facility's operation, and the Systematic Internal Review Program (SIR), a program of ongoing reviews in each VA facility conducted by designated committees made up of physicians and other health professionals from the facility's own staff. Both components of the VA's quality-assurance program produce various documents which contain information identifying individual VA patients or employees, such as those conducting the reviews or health-care professionals providing care, citing and describing instances of inappropriate medical practices and deficiencies discovered in the care provided, and making recommendations for corrective actions.

Because these quality-assurance efforts depend to a very significant degree on the willingness to be completely candid in their comments on the part of the VA personnel conducting the reviews and because of concerns that this vital degree of candor could be lost if the participants could not be assured that their remarks and evaluations incorporated in SERP and SIR reports would be kept confidential, the Congress acted in 1980 in section 505 of Public Law 96-385 to place stringent limitations on the disclosure of these documents.

However, there have been a number of recent reports of situations in which various VA facilities have relied on section 3305 to refuse disclosure of information and records which were not generated by SERP or SIR reports and which did not appear to come within the coverage of that section. In some of these cases, the material requested consisted of aggregate data relating to morbidity and mortality rates for various procedures at VA health-care facilities, information that resulted from a simple compilation of information and which did not implicate any quality assurance activity.

The VA strongly opposed this provision as introduced because no exception from disclosure was than provided for mortality and morbidity data which would identify an individual health-care provider. As is discussed in more detail below, the Committee responded to this concern by amending the provision as introduced to retain confidentiality for such data under section 3305 (except to the extent that such data are included in the three biennial reports to be submitted to the Committee on Veterans' Affairs pursuant to new section 4152 proposed to be added to title 38 by section 304(a) of the Committee bill (discussed below)).

Committee bill

Section 302 of the Committee bill is, therefore, designed to ensure that the intent of Congress in enacting section 3305 is clear—namely, that medical quality-assurance records should be kept confidential but only to the extent necessary to promote the candor of individuals involved in the quality-assurance process and to protect individual privacy interests. Thus, the Committee bill would specify that generally the withholding of aggregate data re-

lating to morbidity and mortality associated with various VA programs, a withholding which is not necessary to achieve the purpose of promoting candor, is neither required nor authorized. This provision would make clear that such aggregate information—except to the extent that it explicitly or implicitly would identify an individual VA patient or employee or an individual involved in a quality-assurance activity—is not confidential as part of medical quality-assurance records. Thus, unless some other basis for nondisclosure exists, the information would be available for disclosure. According to the VA, the exception to the disclosure availability limitation would affect 250 surgical specialty programs out of a total of perhaps 1,000 within the VA which have only a single staff physician, full-or part-time. Any data about such programs would obviously be identifiable to the individual surgeon. The breakdown by specialty of these 250 surgical specialties that have a single surgeon are:

Anesthesiology	16
General Surgery	8
Gynecology	8
Neurosurgery	22
Oncology	2
Ophthalmology	24
Orthopedics	29
Otorhinolaryngology	24
Plastic and Maxillo Facial	28
Proctology	3
Thoracic	37
Urology	49
Total	250

Retaining confidentiality for aggregate data which explicitly or implicitly identifies certain individuals is similar to the policy contained in final regulations issued by the Department of Health and Human Services relating to disclosure of information derived through the Utilization and Quality Peer Review Organization Program under Medicare (50 Fed. Reg. 15,348, 15,362 (April 17, 1985) (to be codified in 42 C.F.R. § 476.120(7))).

Finally, this section of the Committee bill would amend section 3305 to specify that the three biennial quality-assurance reports to be submitted to the Congress pursuant to new section 4152 that would be added by section 304 of the Committee bill are *not* included within the scope of the section 3305 confidentiality protections. The provision in the proposed new section 4152 that would be added by that section of the Committee bill would provide that the reports required to be submitted pursuant to that new section—biennial reports on the agency's experiences under a new quality-assurance program, the first of which would be due January 1, 1987—are not to be considered records or documents for purposes of section 3305 and thus would not be made confidential under section 3305. Inasmuch as these reports would include data on mortality and morbidity rates for all VA surgical programs, such information would thereby be available for public information every 2 years. The Committee believes that this periodic availability of morbidity and mortality data in the context of a report on the agency's overall quality-assurance efforts would strike a reasonable balance between the public's right to know and the need to main-

tain the confidentiality of certain aggregate data that would be protected under section 3305 as it would be amended.

Disciplinary Board Action Involving Clinical Privileges

Section 303 of the Committee bill, which is derived from section 8 of S. 6, would amend section 4110 of title 38—which prescribes, in broad outline, the procedures for disciplinary cases involving certain VA health-care personnel—so as to make that section expressly applicable to a proposed reduction or revocation of clinical privileges that is based on a deficiency in the individual's clinical practice.

Background

The Committee believes tht clinical privileges are a very fundamental component of a physician's or other health-care professional's employment with the VA and indeed of their proprietary interest in their profession. Without these privileges such individuals would be prevented from exercising their professional skills. In this regard, the Committee believes that they should be at risk of loss or reduction only in a situation in which they have been put on notice and that any action to so restrict clinical privileges must be based on finding of a deficiency in the individual's clinical practice. Also, the Committee strongly believes that clinical privileges are directly related to quality of care and patient safety and, as such, the agency has a grave responsibility to ensure that clinical privileges are judicially granted, monitored, and revoked.

The VA strongly opposed this provision, taking the position that "privileging" should remain separate from disciplinary action. The basis for this position seems to be that a proposed reduction or revocation of clinical privileges is not a true adverse action because the individual physician whose clinical privileges are revoked or reduced is still employed by the VA. The Committee believes that such an individual has suffered a certain significant loss and that, therefore, section 4110 should apply in such cases, so as to afford the full due process protections—such as the right to notice of the basis for the proposed action, the right to confront all witnesses giving evidence, the right to be present throughout the proceedings, and the right to a decision on the record—that apply in section 4110 proceedings.

Also, the VA noted that the new procedural requirements that this provision would impose "could delay the withdrawal of clinical privileges even if the health and safety of veteran patients were threatened." The point seemed to be negated by the testimony of the VA's Assistant General Counsel, Audley Hendricks, in response to a question from Senator Cranston as to whether the VA has the authority under present section 4110 to remove a health-care professional from contact with patients during the pendency of disciplinary proceedings. Mr. Hendricks indicated that the VA has such authority, although he expressed the view, that, rather than falling under section 4110, it was based on the agency's administrative authority to "direct a physician or employee to do certain activities". Subsequent written answers provided for the hearing record by the VA referred to the inherent authority to reassign or detail an em-

ployee. Nonetheless, in order to remove any possible doubt on this score, the Committee bill, as is discussed in more detail below, makes this authority express.

Committee bill

The Committee bill would limit the power of a disciplinary board to reduce or revoke privileges by requiring that, before this could be done, appropriate notice must first be provided to the employee. In addition, in response to concerns that this provision might somehow limit the agency's ability temporarily to reassign a health-care professional so as to remove his or her access to veteran-patients, the Committee modified the provision so as to add to section 4110 an express provision specifying that nothing in section 4110 restricts the Administrator's authority to reassign a health professional for the purpose of suspending the exercise of clinical privileges or otherwise restricting such employee's professional activities to the extent necessary to protect the health or safety of veteran-patients, all pending the outcome of a 4110 proceeding. This provision would simply codify the current state of the law on this point as described by VA Assistant General Counsel Audley Hendricks at the May 7 hearing. Hence, this provision does not in any way expand the VA's authority to act in this area over its current authority.

The Committee notes that, in connection with its consideration of issues relating to the VA's credentialing of physicians and other health-care personnel (discussed below), a question arose as to the extent to which the agency should report information to non-VA entities regarding actions involving clinical privileges. Although final resolution of that issue will await the VA's completion of the report required by section 304(c) of the Committee bill, the Committee notes that, as a result of the changes proposed in this section of the Committee bill with respect to actions involving clinical privileges, any actions reducing or revoking these privileges would only have been taken with employees having appropriate due process protection. This would serve to ensure that any disclosure involving the elimination of revocation of privileges would be appropriate.

Quality Assurance and Credentialing

Section 304 of the Committee bill is derived from section 5 of S. 876. This provision would require the Administrator to: (1) establish and conduct a comprehensive quality-assurance program to monitor and evaluate the quality of health care provided by the Department of Medicine and Surgery (DM&S); (2) delineate the responsibilities of DM&S with respect to the conduct of the VA quality-assurance program; and (3) allocate sufficient resources and sufficient personnel to DM&S to enable it to carry out its quality-assurance responsibilities. The Inspector General (IG) would be required to allocate sufficient resources and sufficient personnel to monitor the quality-assurance program conducted by DM&S. The Administrator would also be required to: (1) identify morbidity and mortality standards for all types of surgical procedures; (2) collect data on morbidity and mortality rates for all such procedures and

compile those data for each VA cardiac surgery, heart transplant, and renal transplant program and in the aggregate for all other VA surgical procedures; (3) compare the aforementioned data to the morbidity and mortality standards, analyze the data, evaluate the data to determine whether there are significant deviations from the standards that would indicate deficiencies in the quality of care, and, if so, to explain any such deviations; and (4) make any recommendations based on the data compiled and the comparisons, analyses, evaluations, and explanations made concerning the data. The Chief Medical Director would be required to submit to the Administrator a report, not later than January 1, 1987, 1989, and 1991, on the experience under the quality-assurance program. Not later than 60 days after having received each report, the Administrator would be required to submit the report to the House and Senate Committees on Veterans' Affairs, with any comments the Administrator wishes to add.

The Committee bill would also require the Administrator to submit a report to the Congress on the agency's plan for the monitoring of credentials of VA health-care professionals. The report would include a description of the VA's policies, procedures, and formal arrangements regarding the exchange of appropriate information with appropriate public and private entities regarding the current and past licensure and clinical privilege status of health-care professionals who are (1) seeking employment with the Veterans' Administration, or (2) currently employed, or (3) whose employment has been voluntarily or involuntarily terminated because of clinical incompetence. In the event that such policies, procedures, or formal arrangements have not been implemented at the time the report is submitted to the Congress, the Administrator would be required to include in the report a timetable for the implementation of such policies, procedures, and arrangements and a progress report every 3 months until full implementation and, at that point, a final report would be required to be submitted to Congress.

Background

On September 20, 1980, the VA established the Office of the Medical Inspector to monitor the quality of care within DM&S. One year later, DM&S's Evaluation and Analysis Office, charged with systemwide evaluations of VA care, was combined with the Office of Medical Inspector to form the Medical Inspector and Evaluation Office. The Medical Inspector was given responsibility for all functions pertaining to the monitoring and evaluation of the quality of care provided by DM&S, including the investigations of specific incidents involving a VA patient and the evaluation of the overall quality of care provided at VA hospitals. On October 22, 1982, the VA issued regulations, pursuant to Public Law 96-385, the Veterans' Disability Compensation and Housing Benefits Amendments of 1980, enacted on October 7, 1980, which defined the VA's quality-assurance program, Health Services Review Organization (HSRO), and provided confidentiality for certain quality-assurance records.

In December 1983, the Committee requested the General Accounting Office (GAO) to conduct a review of the Office of Medical

Inspector and Evaluation to provide the Committee with information concerning the general operation and effectiveness of the Medical Inspector's Office. GAO was also asked to examine the functions and relationships of the Medical Inspector, VA Medical Center Directors, the Chief Medical Director, and the VA Inspector General relating to quality assurance.

On June 6, 1984, the Committee held an oversight hearing to receive testimony on the VA's policies and practices relating to quality assurance, including the role of the Medical Inspector's Office in ensuring the implementation of quality-assurance policies and the monitoring of quality-assurance activities. The Committee was specifically concerned about the following issues, among others: (1) identifying the VA's major quality-of-care problems; (2) the need for systematic analysis of data to identify, prospectively or retrospectively, trends in quality-of-care deficiencies; (3) the standards and procedures applied to monitor the competency of VA healthcare personnel; (4) the implementation of the HSRO program; (5) the need for coordination of numerous VA offices and individuals with specific quality-assurance roles into a cohesive quality assurance program; (6) the priority within DM&S accorded to the Medical Inspector's mission, to the independence of the Medical Inspector, and to the availability of sufficient resources and sufficient personnel to enable the Medical Inspector to accomplish this mission; and (7) the role of the IG in monitoring the quality-assurance activities of the Medical Inspector, the independence of the IG relating to such monitoring, and the availability of sufficient resources and sufficient personnel to enable the IG to accomplish these responsibilities. Testimony was received on these and other matters from the VA, the Department of Defense (DOD), and Dr. John Beary III, Associate Dean, Georgetown University School of Medicine, former Principal Deputy Assistant Secretary of Defense for Health Affairs.

The Committee is aware that a July 29, 1982, DOD Directive, "Dissemination of Information on Medical Officers", set forth certain policies and procedures for the monitoring of credentials of DOD physicians. The directive states:

> Appropriate professional regulating authorities [such as the Federation of State Medical Boards] shall be notified of the identity of medical officers who are separated, whose employment is terminated, or who retire while their clinical practice privileges are suspended, limited, or withdrawn. This requirement does not apply when the suspension, limitation, or withdrawal is for administrative reasons (such as inadequate equipment and lack of qualified support personnel).

The directive further provides that,

> In any case whereby a medical officer's clinical practice privileges are suspended, limited, or withdrawn, a command review shall be conducted to determine whether the officer should be considered for separation or termination. If the medical officer whose privileges are suspended, limited, or withdrawn is not separated or terminated, and he

> or she seeks training at a civilian institution or organization, such institution or organization shall be notified of the actions in question. When a medical officer is ordered to practice or receive training in a military or civilian facility other than that a which his or her credentials file is maintained, the gaining facility shall be informed fully of the officer's qualifications, including disclosure of suspension, limitation, or withdrawal of clinical practice privileges.

The directive also provides that,

> A medical officer may not be separated or terminated at the discretion of the DOD Component concerned while the subject of a credentials review process, except that separation of termination may be authorized in unusually compelling cases by the Secretary of the Military Department concerned.

On April 19, 1983, a DOD Directive, "Standards for DOD Health Care Provided Performance", also set forth policies and procedures requiring the establishment of "complication snd mortality rate norms to be used as standards against which DOD health-care provider performance shall be measured."

The Committee is aware that as DOD IG audit report covering the period May 1983 through October 1984 has raised questions about the extent of which these quality-assurance programs have been fully implemented in the armed services. Nevertheless, the Committee believes that DOD's written quality-assurance policies should provide useful guidance for consideration by the VA in reviewing and revising its quality-assurance and credentialing programs and policies.

In followup to the Committee's December 1983 request to GAO, subsequent meetings between GAO staff and Committee staff, and the Committee's June 6, 1984, hearing, the Committee requested, on September 6, 1984, that GAO expand its review to examine certain unresolved issues and questions related to the VA's quality-assurance program, including the following: (1) the relationship between the Inspector General and the Medical Inspector; (2) the implementation of the Systematic Internal Review Program at VA medical centers; (3) the role of DM&S Regional Directors in VA's quality assurance activities; (4) the protection of DM&S employees who report quality-of-care deficiency incidents; (5) the resources allocated to the Medical Inspector; and (6) the diversion of responsibility for investigating medical issues within the VA compared with the approach adopted by DOD.

GAO's final report, "VA Has Not Fully Implemented Its Health Care Quality Assurance Systems", released on June 27, 1985, found that, first, VA medical centers had not implemented the quality-assurance programs required by VA's October 22, 1982, HSRO regulations and, second, the Medical Inspector was not evaluating the effectiveness of the centers' programs, GAO found that the 13 VA facilities which it examined either did not perform or only partially carried out the 5 mandatory HSRO functions (i.e., continuous monitoring of 15 separate clinical elements, patient injury control,

utilization review, problem-focused health-care studies, and review of the credentials of health-care professionals). GAO stated. "As a result, the centers did not systematically (1) determine whether health care and services provided were appropriate to patient needs, (2) determine patterns and trends of health care provided, and (3) resolved systemic quality of care problems." However, GAO also noted that because it "did not analyze the effectiveness of the medical centers' quality-assurance activities, it could not conclude that medical centers' failure to comply with VA's requirements resulted in poor quality of care. Nor would full compliance necessarily assure high quality of care."

With respect to the Medical Inspector's oversight of medical centers' quality-assurance programs, Systematic External Review Program (SERP), GAO found: (1) SERP reviews have not evaluated the effectiveness of centers' quality-assurance programs; (2) although VA planned to conduct 60 SERP reviews annually, it had not achieved this goal since fiscal year 1977, averaging 44 reviews annually since then; and (3) some reviewers and center officials believe that the amount of time devoted to conducting each review is too short.

The Committee notes that the VA chose not to comment on the descriptions, observations, and findings contained in the GAO report, as is the general practice prior to the release of GAO reports on VA programs. However, since the Committee began its recent review of the VA's quality-assurance program, the VA has taken certain steps to improve its quality-assurance efforts. Specifically, Acting Chief Medical Director Dr. John Gronvall on July 12, 1984, provided guidance to all VA Regional Directors, Medical Center Directors, and others on the need to address repeated Joint Commission on Accreditation of Hospitals (JCAH) deficiencies, including repeated and frequent deficiencies in quality assurance. On December 14, 1984, the IG and Chief Medical Director Dr. John Ditzler signed an agreement to implement a formal working relationship on their respective quality-assurance activities. And on March 3, 1985, the Chief Medical Director established an Office of Quality Assurance within DM&S assigning to this new office reporting directly to the Chief Medical Director, the functions of the quality-assurance and evaluation activities, proviously performed by the Medical Inspector. Among other activities, the Office of Quality Assurance will establish a Medical District Initiated Peer Review Organization (MEDIPRO) process, which will involve the systematic review and evaluation of clinical indicators of patient care by physicians and health-care professionals.

VA testimony presented by Deputy Chief Medical Director Gronvall at the Committee's May 7, 1985, hearing reiterated the VA's commitment to the maintenance and continued improvement of an effective medical quality-assurance program and outlined the new emphasis being given to quality assurance by the new Chief Medical Director.

Committee bill

Quality assurance: In an effort to take into account the VA's recent initiatives in the quality-assurance area and its specific concerns about certain aspects of section 5 of S. 876, the Committee

bill makes certain modifications in the provisions. The Committee continues to believe that an effective quality-assurance program is an essential component of the VA's responsibilities to provide high quality health-care services for veterans and merits inclusion as a specific priority in title 38, United States Code, the body of law governing the programs and services administered by the VA. The Committee also believes that without a clear delineation of responsibilities and resources to implement such responsibilities, any such program would be difficult to conduct and monitor.

With respect to the morbidity and mortality standards and data, the Committee recognizes the sensitive nature of such information and certain limitations regarding the use of such statistics and has incorporated certain changes in the Committee bill to take these factors into account. By requiring in the Committee bill that the VA analyze the morbidity and mortality data in light of specific patient characteristics and the level of risk of surgical procedure involved, the Committee believes that the chances would be substantially reduced that data would be misinterpreted by the Congress, veterans, and others and that viewed in that context those data could serve as a useful quality-assurance indicator. Further, by requiring the VA to report to Congress every other year through January 1991, the Committee bill seeks to strike an appropriate balance between, on the one hand, the need to provide veterans, as consumers of VA health/care services, as well as the Congress and the public, with important information about the quality of VA care and, on the other hand, the need to enable the VA to manage its health-care system without undue administrative burdens. The Committee notes that the VA already compiles mortality statistics for each of its cardiac surgery programs and informally maintains, at the program level, information concerning the results of heart transplant and renal transplant procedures.

Credentialing: With respect to the provision in the Committee bill relating to credentialing of VA health-care personnel, the Committee has followed an evolving trend in quality-assurance programs to place an increased emphasis on credentialing procedures. The JCAH has revised its 1985 Accreditations Manual for Hospitals to emphasize, in part, medical staff competence, credentialing, and reappointment procedures. These changes were effective on January 1, 1985. In addition to these revised accreditation standards and other Federal and State initiatives to improve the credentialing process, case law relating to malpractice judgments has identified certain duties that a health-care facility owes to its patients. *See Elam* v. *College Park Hospital*, 132 Cal. App. 3d 322 (1982); and *Johnson* v. *Misericordia Community Hospital*, 301 NW 2d 156 (1980) and cases cited therein. These duties include:

—The duty to acquire knowledge of current and past licensure and clinical privilege status prior to employment or granting of clinical privileges.

—The duty to carefully screen and make appropriate inquiries on applicants for hospital privileges.

—The duty to monitor and supervise the competency of its medical staff through appropriate quality-assurance mechanisms.

—The duty to notify appropriate state and private agencies of disciplinary actions, impaired capacity, or incompetence.

The Committee believes that accurate and truthful information is basic to the preservation of the integrity of the credentialing system in the health-care field. In order to meet this responsibility, the implementation of a uniform credentials monitoring system and procedures for the exchange of appropriate information with appropriate agencies and licensure bodies is essential. A December 3, 1984, Medical Inspector and Evaluation Office letter to VA Regional Directors and Directors of VA Medical Centers and other VA facilities noted that from January 1982 through March 1984 the JCAH cited 115 deficiencies based upon standards which involve some aspect of credentialing and/or privileging. The VA has indicated to the Committee that efforts are being taken to implement reforms in this area and that these new procedures generally will be in place by the end of 1985. In view of these efforts, the Committee has refrained from directing a specific credentialing program. However, the oversight responsibility of this Committee and the critical importance of this issue to patient safety and quality of care require that the Committee continue to monitor closely the implementation and functioning of these program changes.

Toward this end, the Committee bill would require the Administrator to submit, not later than 90 days after enactment, a report to the Congress on the agency's plan for the monitoring of credentials of VA health-care professionals. In the event that the VA has not implemented its policies, procedures, and formal arrangements for such monitoring at the time the report is submitted, the Administrator would be required to submit a progress report every 3 months until the plan is fully implemented.

Finally, the Committee notes its views that the VA, as part of its efforts to implement credentialing monitoring programs, should exercise caution when disclosing to nongovernmental entities (such as the Federation of State Medical Boards) information concerning the credentials of VA physicians and other health-care professionals. Such information should be limited in such a way as to provide only so much specific information as would alert a properly interested party to the fact that the VA may have relevant information that the party could then seek directly from the VA.

TITLE IV—MEDICAL FACILITY CONSTRUCTION AND PLANNING

Annual Veterans' Administration Medical Facility Construction Authorizations

Section 401 of the Committee bill would make a number of changes in the manner in which this Committee and the Committee on Veterans' Affairs of the House of Representatives consider and approve the VA's annual medical facility construction project proposals. In addition, this section would make various amendments to existing law designed to give the Congress greater input in and control over the VA's construction, remodeling, and expansion of existing or new medical facilities.

Background

Under current law—section 5004 of title 38—no appropriations may be made for major VA medical facility construction projects

(those involving the expenditure of more than $2 million) unless both Committees on Veterans' Affairs have first adopted a resolution approving the project and setting forth the estimated cost thereof. This Committee resolution approach originated in legislation developed by the House Committee and enacted in Public Law 96-22, taking effect on October 1, 1979.

However, last year, the prohibition against the making of appropriations either for projects that have not been approved by the Committee or in excess of the amount specified in the resolutions, was circumvented because the Appropriations Committee did not make appropriations for specific major construction projects, as had always been the practice, but rather included lump sums for major construction (H.R. 5713, H. Rept. No. 98-803, 98th Cong. 2d Sess., pages 50-52; S. Rept. No. 98-506, pages 96-101) and required the VA to advise the Appropriations Committees by September 1, 1984, as to the projects for which the sum finally appropriated ($568.2 million by virtue of adoption of the conference report on H.R. 5713 (H. Rept. No. 98-867)) would be used. Hence, although on May 24, 1984, this Committee approved, in its resolution for fiscal year 1985, ceilings on appropriations that could be made for seven major replacement or modernization construction projects (Allen Park, Michigan; Augusta, Georgia; Baltimore, Maryland; Houston, Texas; Mountain Home, Tennessee; New York, New York; and Philadelphia, Pennsylvania), appropriations were ultimately directed to five of these projects (Augusta, Houston, Mountain Home, New York, and Philadelphia) far in excess of the amounts approved by this Committee. (See H. Rept. No. 98-1030, 98th Congress, 2d Sess., pp. 13-14, and S. Rept. No. 98-634, 98th Congress, 2d Sess., pp. 24-25, accompanying the continuing appropriations resolution for fiscal year 1985, enacted as Public Law 98-473.)

Committee bill

In order to clarify the situation and restore the Veterans' Affairs Committees to the roles in the consideration of VA construction projects that the Congress clearly intended in enacting Public Law 96-22, this section of the Committee bill would institute an annual-authorization-of-appropriations legislation approach in lieu of the resolution approach. Under this approach, an appropriation could not be made for a major VA medical facility construction, alteration, or acquisition project except in accordance with a law based on legislation reported from the Committees on Veterans' Affairs setting forth the amount that may be appropriated and expended for the project. This would ensure that the authorizing committees' positions regarding VA medical construction projects are given consideration commensurate with the committees' responsibilities, knowledge, and insights regarding the VA health-care system.

In addition, this section would make a change designed to give the Congress earlier, more effective input into the planning of major replacement and modernization projects and more meaningful control over the size of such projects. Under current law, the advanced planning fund provides resources for the development of even the very largest hospital construction projects through the preliminary-plans stage well before there is any structured opportunity for Congressional input. That opportunity does finally

arise—usually years later—in response to the VA's request for funding of working drawings and actual construction activities. By that time, the agency may already have committed years of effort and millions of dollars into a construction concept and bedsize that the Congress has not approved or even been given an opportunity to review.

As the Committee has learned in connection with its consideration of the VA's request for fiscal year 1986 funding of three major replacement/modernization projects (Houston, Texas; Mountain Home, Tennessee; and Philadelphia, Pennsylvania), any Congressional control over a large project—other than a decision to proceed or not to proceed—virtually ceases when a project has completed the preliminary planning stage. For example, in connection with the construction of a replacement medical facility in Houston, Texas, the VA has advised the Committee that to redesign the preliminary plans for the project to conform with the Committee's recommendations as set forth in its May 24, 1984, construction resolution (to reduce the number of hospital beds from the planned 919 to 685) "would take about 25 to 35 months". The Committee's views accompanying and explaining that resolution are printed as an Appendix to this report.

Such a delay to redesign preliminary plans could defer the construction schedule up to 3 years, which could (and did in the case of the Houston project particularly) obviously engender serious resistance to making what the Committee believes would be a very desirable change in the bedsize of the facility.

The Committee notes with dismay and great frustration the exchanges that occurred between VA witnesses and Committee Members—Senators Murkowski, Simpson, and Cranston—at the Committee's March 27 hearing on construction during which the VA refused to acknowledge the possibility or feasibility of expediting the following: (1) its lengthy construction planning process, and (2) its planning and design process for the purposes of redesigning certain already designed construction projects to reduce the size of the projects to conform with the Committee's approvals set forth in last year's construction resolution.

The line of hearing questioning which follows illustrates this point, especially the reluctance of the VA to look for alternative, expeditious ways to respond to the Committee's concerns.

> Senator CRANSTON. I would like to go directly to some questions.
>
> First of all, on the matter of the Texas hospital that we have been hearing about, I would like to ask you, Dr. Gronvall, about the allegations that there would be such a tremendously long delay if the institution were to be downsized. I cannot understand how it could take the long time that has been suggested to revise those plans and proceed with a lesser-sized institution that would be more in keeping with the apparent real needs.
>
> We have had some statements by experts in the field who indicate that it should be possible to revise those plans within 3 to 6 months and get going and, thus, not

have any significant delay. I would like to hear an explanation of why that is not possible.

Dr. GRONVALL. We are pleased to, Mr. Cranston. Let me ask Susan Livingstone to comment on the steps that we would have to go through if we significantly downsized the hospital and what would be required in revisiting the plans and the relationships of various elements, of beds, and supporting elements in the hospital.

Ms. LIVINGSTONE. Thank you.

Senator Cranston, the time that would be consumed—and I know the VA has provided figures—it would range up to about 36 months. We feel or hope that would be——

Senator CRANSTON. It would be 36 months?

Ms. LIVINGSTONE. That is correct, sir.

Senator CRANSTON. I cannot comprehend that timespan.

Ms. LIVINGSTONE. What basically would occur on the downsize of Houston to the degree which has been presented to the Veterans' Administration, the VA would basically have to go back to the very beginning planning concept of the project. The Department of Medicine and Surgery would have to make determinations based on the new bed sizing, if there should be significant changes in the services and types of beds that are going to be offered. That decisionmaking takes time. There should be coordination with the medical center and the field as well.

Once those decisions are actually made then we need to go back and reassess the work loads and data packages we would use to develop conceptual design solutions. We do have a selected design solution now for 10,000—or a 1,047-bed level. If you go to a 600- or 700-hundred bed hospital the design would be totally different.

So it basically is not just taking off, for instance, a wing or a floor of the current design, we would have to totally redesign.

Senator CRANSTON. Well, I would think you could bring in the various people that would play various parts of that, put them in one place for a week and resolve those questions.

This is the most absurd statement of bureaucratic delay and consequent expense to taxpayers that I have heard of recently.

Ms. LIVINGSTONE. The programing decisions within the Department I am sure could be fast tracked, sir, I mean in terms of going back and determining what services to remove. Then what the major delay discussed here is in the design solution. And basically, the preliminary plan design, which was done by a contracted AE and not by the VA, took 13 months alone for the current hospital. We would have to go back and reperform those plans for the new design configuration.

Senator CRANSTON. You have done most of that siting work already.

I was around here during World War II when the Pentagon was built, the largest building around here. And that

was done very, very swiftly because there was a need. There is a need here. And I just cannot understand that kind of an incredibly bureaucratic, redtape, slow approach to a serious problem. It is a can't-do rather than a can-do approach. And I am disgusted with that attitude. I really am.

Ms. LIVINGSTONE. Sir——

Senator CRANSTON. I seldom get as aggravated as I am over this situation. It is the worst foot dragging that I have seen by the bureaucracy, and bureaucracy is the word to describe it.

Ms. LIVINGSTONE. Believe me, we are very concerned at the VA as well about the length of time it takes us to design and construct our facilities. And that is what prompted the Administrator to contract with Booz-Allen and RTKL to do an entire study of these procedures.

What I am talking about, however, is not our internal mechanisms, but I am talking about what our contracted AE, how long it took that firm to design the current facility. And that was 13 months alone.

Senator CRANSTON. Well, maybe you need a better firm. If they have done that basic work, it does not take as much to change the fundamental plan where much of the work done for the original plan applies to any revisions of the plan.

There is no use arguing about it. But I would like to have a written statement in detail outlining why you cannot do it, explaining all the reasons you cannot, but also explaining how you might do it if you can do that.

Ms. LIVINGSTONE. Okay. The——

Senator CRANSTON. Let's not discuss it anymore at this point.

Ms. LIVINGSTONE. Okay. Technically it can be done. It is just it deals with the question of time.

Senator CRANSTON. Of course it can be done. The question is time and expense. Let's take another look and see if you cannot come up with a more reasonable approach to it.

Dr. GRONVALL. Sure. We will be happy to revisit the question and supply a detailed response, Mr. Chairman.

Senator CRANSTON. I beg your pardon?

Dr. GRONVALL. We will be happy to supply a detailed response.

Senator CRANSTON. Would you please relay my concerns to Mr. Walters?

Ms. LIVINGSTONE. Certainly will, sir.

Dr. GRONVALL. Certainly will.

Prior to that hearing, Senator Cranston had communicated similar concerns in a March 18 letter to Administrator of Veterans' Affairs Harry Walters. Citing the Committee's May 24, 1984, construction-approval resolution, he urged the Administrator to take all steps necessary as quickly as possible to enable construction in Houston, Philadelphia, and Mountain Home to proceed, at the ear-

liest possible time during fiscal year 1986, in a manner consistent with the approach reflected in the Committee's resolution.

On June 19, three full months later, the VA Administrator replied to Senator Cranston's letter, indicating that the VA would proceed with the construction of the three projects as previously planned.

[The exchange of letters follow:]

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 18, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

I am writing on a matter of urgent concern to me regarding the VA's construction of major replacement/modernization projects and, specifically, the major projects scheduled to receive construction funding in FY 1986: Houston, Texas; Philadelphia, Pennsylvania; and Mountain Home, Tennessee.

As you'll recall, last May the Senate Veterans' Affairs Committee approved these and other VA medical construction projects with hospital bed-sizes that were less than the VA had proposed and that corresponded appropriately to the needs of service-connected-disabled veterans and financially needy veterans. It is my position that the VA should now proceed in the most expeditious fashion with construction on these three projects in a manner that is consistent with the views of the Committee as they were expressed in the statement of views (a copy is enclosed) accompanying its resolution, dated May 24, 1984, providing for a Houston replacement facility of approximately 685 hospital beds, a Philadelphia facility of approximately 369 hospital beds, and a Mountain Home facility of approximately 387 hospital beds (these figures do not include any nursing-home beds planned for those facilities).

In this regard, I urge you to proceed immediately to take all steps necessary to permit construction in Houston, Philadelphia, and Mountain Home to proceed in a manner consistent with this approach at the earliest possible time during FY 1986. I note that since the only construction activities scheduled to begin during FY 1986 in Philadelphia are the nursing-home-care unit, pedestrian bridge, and parking lot, hospital-bed resizing should produce no delay in completing that project. In the cases of the other two projects, available funds in the VA's major construction account working reserve, or any other available funds, should be used now for revising the preliminary plans for the projects so that working drawings can be accomplished which will reflect the revised size of the projects and the projects will not be delayed to any significant extent.

I believe that if the VA undertakes these revisions as a top priority, the planning for these projects could be redone quickly. DM&S has advised that its normal process of review, dispute resolution, and appeal would require at least seven months merely to make the specific downsizing decisions. I believe that if the key people from the VAMC were brought to Central Office to work with DM&S and Office of Construction officials and all met together, the basic decisions could be made expeditiously. Independent A&E firms have advised that it is possible for redesign of the preliminary plans to be done in 3-6 months if there is maximum cooperation. Moreover, any delays thus encountered during the planning stages could be further minimized thereafter since smaller facilities should take less time for working drawings to be completed, to be constructed, and to be made operational. Ultimately, therefore, it would appear to me that the projects could be completed within periods of time close to the current schedule.

What is needed is a "can do" rather than a "can't do" approach.

With respect to the Houston facility specifically, I note that I have been advised by a number of persons with extensive experience in hospital management, including former Chief Medical Director Dr. Donald L. Custis, that any facility bigger than 700 hospital beds presents severe management problems. My 16 years' experience with the operation of the 1,100-bed VAMC at Long Beach, California, confirms that position.

Moreover, I trust that it is not the contention that 700 hospital beds is too few to facilitate the operation of the hospital efficiently and effectively in order to to provide care for the 8.4 percent of that facility's patients being treated for service-connected conditions and the additional 12.4 percent who have service-connected conditions but are receiving care for a non-service-connected condition.

The same analysis applies to the other six facilities, none of which has a service-connected inpatient caseload (combining these two categories) of over 40 percent. In fact, the combined service-connected caseloads at all but the Allen Park and Augusta facilities do not exceed 26 percent, considerably below the VA system-wide service-connected average of about 30 percent. Further, the percentage of patients at these five facilities who have no service-connected disability or do not receive VA pension averages well over 55 percent. So it is clear that generally well over half the beds proposed for each facility are being proposed for the care of non-service-connected veterans who may not be financially needy. (The above figures -- provided by the VA for last year's construction resolution -- are the most current available to us.)

Given the pressing need to curb Federal spending -- both now and in the future -- in order to reduce the projected deficits, I believe it is imperative that the VA develop an approach to sizing hospitals that seeks to allocate scarce funding over a greater number of projects in order more equitably to serve veterans across the Nation. Such a reallocation approach, stressing service-connected and pension-eligible veteran care, should be undertaken both with respect to these three projects as well as the other four that the Committee approved last year (Allen Park, Augusta, New York, and Baltimore) in a manner that reflects the Committee's position on the sizes of these proposed facilities.

I would appreciate your personal and prompt attention to this request.

With warm regards,

Cordially,

Alan Cranston
Ranking Minority Member

Enclosure

cc: Honorable Frank H. Murkowski
Honorable Jake Garn
Honorable Patrick J. Leahy
Honorable Lloyd Bentsen
Honorable Phil Gramm
Dr. John W. Ditzler

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

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Administration

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Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Cranston: alan

I am pleased to respond to your letter of March 18, 1985 in which you recommend that the Veterans Administration proceed with construction at VA Medical Centers at Houston, Philadelphia, and Mountain Home at levels generated by the sizing model developed by the Senate Veterans' Affairs Committee.

I recognize your concern in this matter and assure you that the SVAC model has been given careful consideration since it was developed by the Committee last year. I believe that implementation of a bed-sizing model that has the potential to negatively affect the provision of services to eligible veterans should be considered only after broad public discussion and participation.

The VA model was developed, at the direction of Congress, by a group from the VA and the General Accounting Office. It is a well thought out model that considers not only VA historical experience, but also community factors such as length of stay. It is also responsive to the VA's legislative mandate to care for eligible veterans. As such, and because of broad public acceptance of the model, I believe it is more appropriate to size facilities utilizing its output. Therefore, I believe we should proceed with the projects as submitted in the original Fiscal Year 1986 construction budget request. I am enclosing a fact sheet prepared by the Chief Medical Director, addressing this issue in greater detail.

The support that you have given to the Veterans Administration in the past has been extremely important to the health care needs of the Nation's veterans. We therefore seek your continued support with repect to the submitted medical facility construction projects.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

Enclosure

Fact Sheet Addressing Senator Cranston's Inquiry

ISSUE: Down-sizing Major Construction

DISCUSSION: - Down-sizing the three projects would have a serious impact on the ability to provide needed health care to eligible veterans. A preliminary analysis reveals that it would have profound implications for veterans who are eligible for and in need of VA health care services. Our planning utilizes past trends to project the number of beds needed in the future to care for veterans.

The difficulty of managing a hospital larger than 700 beds is not an issue in determining the need of veterans in an area. The VA presently operates large hospitals. In fact, there are 44 hospitals in the VA system with authorized beds in excess of 700. Our managers are well prepared to deal with the challenges found in administering hospitals of any size. Each facility has its unique characteristics, and each can be managed.

The following is our best estimate of the possible delays that would result if the recommendation to resize the three projects were to be implemented. These estimates reflect a total redesign approach which adjusts not only the bed levels but also the support space in each project. An internal programming of each project would be required as well as Congressional approval required for the scope changes. These time frames presume we could use the same Architect-Engineer firms already hired for each job. When scope changes are of a significant nature, our General Counsel has ruled that we must readvertise the design contract. The time frames also assume that the environmental compliance process for each project would be overlapped within the months given for other actuals. Given these assumptions, we estimate the final design and construction of Houston would be delayed approximately 25 to 36 months. This assumes 6 to 9 months for the reprogramming and scope approval process, 6 to 9 months for the VA redesign of concepts and 13 to 18 months for the Architect-Engineer (A/E) to redesign the preliminary plans. The Mountain Home project would be delayed 14 to 21 months assuming 4 to 6 months for the reprogramming and scope approval process, 4 to 6 months for the A/E redesign of concepts and 6 to 9 months for the A/E redesign of preliminary plans. The Philadelphia project involves the construction of 240 nursing home beds and expansion of ambulatory care and clinical support functions. The effect of downsizing on the support functions would have to be determined. A delay of 20 to 26 months would occur assuming 6 to 8 months for the reprogramming and scope approval process, 4 to 6 months for the A/E to redesign concepts and 10 to 12 months for the A/E to redesign preliminary plans.

The project redevelopment and redesign would be accomplished in keeping with our normal practice of coordination with Medical Center management and clinical personnel to insure that the resultant project meets the specific needs of each Medical Center. This coordination, although time consuming, results in greater user satisfaction with the projects and avoids potential problems later on in construction and in the operation of the facility. Additional details associated with the possibility of revising the Houston project and schedule will be addressed in our submission for the record stemming from the March 26-27, 1985 SVAC Hearing on VA Medical Facility Construction.

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June 12, 1985

The Committee has neither concurred with nor acquiesced in this estimate of the time required for new plans. Nevertheless, it is amply clear that, in order for the Committee and the Congress to have a fully meaningful opportunity to have input into the facility planning processes that in the case of some individual projects represent more than a quarter of a billion dollars in Federal funding for construction alone, a new check on the planning process is required. Thus, the Committee bill would prohibit the expenditure of any funding—beyond what is necessary to develop project requirements—for a project involving estimated expenditures of $20 million or more for the construction, remodeling, expansion, or acquisition of a VA hospital facility unless authorized by a law based on legislation reported from the Committees on Veterans' Affairs. The effect of this provision—which would preclude the VA from developing preliminary plans for large projects which have not been approved by the Congress—would be to give the Congress greater control at an earlier stage in the planning process for large projects, before they have progressed to the point where significant revisions are extremely difficult to achieve.

This provision is not intended to apply to projects to repair or improve an existing VA hospital facility—such as projects for seismic corrections, fire and safety improvements, patient privacy, and asbestos abatement—that do not involve the remodeling or expansion of the facility. These types of alterations do not, as do large-scale renovations of and additions to existing hospitals, raise issues of the mission and appropriate bedsize of the facility that are the focus of the Committee's concern in adding this restriction on preliminary plans for large projects.

Finally, with respect to future projects, the Committee bill would limit to not more than 700 hospital beds the size of VA hospital facilities that could be constructed and would prohibit projects involving expenditures of over $20 million for the remodeling or expansion of a VA facility where, upon completion of the project, the facility would have more than 700 hospital beds.

As noted below in the discussion relating to the new bedsizing model that, under section 402 of the Committee bill, the VA would be required to develop, this provision reflects the Committee's concern, based primarily on its experience in overseeing the operation of the VA health-care system, that VA facilities with over 700 hospital beds—the three largest general medical and surgical facilities have between 1,000 and 1,200 hospital beds—present extremely complex management and logistic problems that can and should be avoided. In this connection, it notes the March 27 testimony of representatives of the Hospital Corporation of America that, in connection with a proposal for a 1,000-bed hospital, they could:

> conceive of no circumstances where [HCA] would consider building a facility this large for a number of reasons. Obviously, the logistics not only of providing staff and services to support that type of size of facility would be tremendous . . . Again, the concern being the momentum of the operation of a facility of that size and the support that is required in not only staffing but also in the system itself, whether it be elevators or mechanical systems, electrical

systems, so forth, must be very sophisticated in a facility of that sort. And the operation of those systems and the staffing of that facility tends to, in our opinion, outweigh the concern for the individual patient in the care that is being delivered.

The Committee has also consulted with hospital management authorities with regard to the maximum number of hospital beds that should be centrally managed. As a result and in light of its concerns regarding the size of VA facilities, the Committee adopted this 700 hospital-bed limitation for future VA planning and construction purposes.

VA Hospital Facility Planning

Section 402 of the Committee bill which is derived with modifications from section 6 of S. 876, would require the VA and the General Accounting Office (GAO) after consultation with the Assistant Secretary of Defense for Health Affairs, veterans' service organizations, and the private hospital industry, to develop, and the VA to implement by April 1, 1987, a new bed-sizing model to replace the VA/GAO bed-sizing model currently being used.

Background

In a May 1978, report, "Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals" (HRD–78–102), GAO described the VA's construction planning process as one which "will result in the construction of the wrong combination or mix of acute care and less critical care hospital beds and too few lower cost options, such as nursing home care, and outpatient facilities." More specifically, GAO found: (1) the VA system was centered around the acute care hospital, (2) the planning model relied on past experience and therefore reflected "the inefficient system of the past", and (3) the planning model did not recognize in a precise way expected changes in the size and age mix of the veteran population. GAO in the report described a new model it had developed to permit new or replacement hospitals to have a range of health-care options consistent with modern medical practice. Subsequently, GAO and the VA met repeatedly over the next 18 months to develop a mutually acceptable model. Such a model was developed, and it was implemented by the VA in January 1980.

Since that time, the VA has implemented another planning methodology, Medical District Initiated Program Planning (MEDIPP), designed to involve administrative and clinical personnel at all levels of the Department of Medicine and Surgery in the formulation and submission of 28 Medical District plans for meeting the health-care needs of eligible veterans in the years 1990 and beyond. The Committee has continually urged the VA to take into account the following factors, among others, in the MEDIPP process: (1) the needs of service-connected veterans, (2) the needs of low-income veterans, (3) the need for and use of alternatives to institutional care, and (4) the availability of existing community-based facilities and services. However, the Committee believes that these factors are not adequately considered in the MEDIPP process. The data determined by the MEDIPP process are used as the basis for

construction projections made through the use of the bed-sizing model. Thus, the VA's failure to incorporate these factors into MEDIPP also skews the VA's construction planning.

On March 23, 1983, the Committee held a hearing to receive testimony on matters pertaining to VA medical facility construction planning. Then-Chairman Simpson expressed concern that "while facilities overall may appear adequate, the available beds may not be of the proper type or in the proper location."

As a result of these concerns and others expressed to the VA on numerous occasions, the Committee, pursuant to section 5004(a), title 38, United States Code, on May 24, 1984, took a new approach in adopting a resolution approving VA medical facility construction projects for fiscal year 1985. In a Committee statement of views accompanying the resolution (reprinted in the Appendix to this report), the Committee, after expressing the Committee's concern that the VA did not, in its sizing of hospitals, take into consideration the statutory priorities for care, described a new formula it developed to determine bed size for new or replacement hospitals or major modernization projects. This model reflected the Committee's belief that statutory priorities need to be taken into account in determining hospital size. The Committee also explicitly stated that the VA should limit the size of new or replacement hospitals in order to maximize the use of increasingly limited construction resources. It therefore approved a total of seven major projects, instead of the five originally requested by the VA, at reduced bed sizes and costs.

Although the Committee expressly conveyed these same concerns to the Senate Appropriations Committee shortly thereafter, that Committee, while noting these concerns in its report on the fiscal year 1985 VA appropriation (S. Rept. No. 98-506, 98th Cong., 2d Sess., pp. 100-101), did not implement our Committee's recommendations. Instead it recommended and the Senate passed a lump-sum appropriation for construction projects without identifying the specific projects either in the bill or the Committee report. Rather the Appropriations Committee directed the VA to reassess its major construction projects request and to submit a list based on that reconsideration to the Appropriations Committees in September 1984. It stated in its report:

> The Committee recognizes the valuable efforts of the Senate Veterans' Affairs Committee in suggesting a bed-sizing model for use in major construction projects (May 24, 1984). The Committee directs the VA to consider the factors in the model such as service-connected disabilities in preparing the September list. In addition, the Committee expects the VA in its September listing to reexamine the size of replacement/modernization projects.

On September 1, 1984, the VA submitted to the Appropriations and Veterans' Affairs Committees a list of the projects for which it intended to use the appropriations that had been made in the HUD-Independent Agencies Appropriations Act for FY 1985, Public Law 98-371. Four of the five major replacement or modernization construction projects originally requested by the VA (in Augusta, Georgia; Houston, Texas; Mountain Home, Tennessee; and New

York, New York) were included. A fifth project that had been included on this Committee's recommendations (in Philadelphia, Pennsylvania) was also included on the VA's September 1 list (see H. Rept. No. 98–1030, 98th Cong., 2nd Sess., pp. 13–14, and S. Rept. No. 98–634, 98th Cong., 2nd Sess., pp. 24–25, accompanying the continuing appropriations resolution for fiscal year 1986, enacted as Public law 98–473). In each case, the amounts identified on the VA list for these five projects were far in excess of the amounts approved by this Committee in the May 24 resolution.

In the VA's fiscal year 1986 budget request, the VA requested funds for three major replacement and modernization projects—in Houston, Texas; Mountain Home, Tennessee; and Philadelphia, Pennsylvania. No attempt was made to take into account the Committee's action in 1984 to downsize individual projects and to limit the number of beds per facility to 700.

In order to further examine the VA's medical facility construction planning procedures, the Committee held hearings on March 26 and 27 of this year. At that time, the Chairman and the Ranking Minority Member again expressed the view that the VA was constructing facilities that were too large and that it would be wiser to build a greater number of facilities with smaller numbers of beds. The Chairman further expressed concern that the VA's current bed-sizing model does not take into account the following:

(1) Statutory eligibility criteria.

(2) Future needs (as contrasted with historical utilization).

(3) Geographic distributin of already existing VA facilities.

(4) Limited availability of construction resources.

(5) Changes in modern medical practice (such as use of non-institutional forms of care, advances in medical technology, and use of health-care cost containment measures).

As a result of, among other things, the testimony received at these hearings, section 6 of S. 876 proposed the establishment of a committee of VA and non-VA experts to, first, review criteria for sizing VA medical facilities and services and the method for determining the criteria and, second, make any recommendations for necessary modifications in the criteria and process.

Issues relating to medical facility construction were addressed during two other occasions before the Committee. During the April 23, 1985, Committee meeting on matters relating to the VA's fiscal year 1986 budget, the Committee adopted a motion to reconfirm its commitment to the policies underlying the Committee's May 24, 1984, construction resolution. And at the Committee's May 7 hearing to examine legislation pertaining to veterans' health care, section 6 of S. 876 was specifically considered.

Committee bill

Following a review of all of the testimony and other information, the Committee modified the provisions as introduced. In order to ensure that decisions regarding the need for and size of each proposed new or replacement VA health-care facility are made taking into account appropriate statutory eligibility and priorities for health care from the VA, section 402 of the Committee bill would require the Administrator of Veterans' Affairs and the Comptroller General, after consultation with the Assistant Secretary of Defense

for Health Affairs, veterans' service organizations, and representatives of the private hospital industry, to develop and submit to Congress a model for determining the appropriate types of hospital beds and the appropriate numbers of each type of hospital bed. This model would replace by April 1, 1987, the VA/GAO bed-sizing model adopted by the VA in January 1980.

The model would be required to incorporate a sizing concept based on the projected needs of service-connected disabled veterans and needy veterans (veterans who meet income-criteria for VA pensions eligibility). The model would have to ensure that factors such as the relationship between the kinds and levels of care provided, i.e., inpatient and outpatient care and alternatives to institutional care, would be taken into account before a decision is made to proceed with a construction option.

The new model would be required to be submitted to the Congress by October 1, 1986, and a joint report on its implementation would be required by October 1, 1987. There would also be a requirement for such subsequent GAO reports as the Comptroller General may consider appropriate regarding the implementation of the model or need for revision of the model.

The Committee bill would prohibit the expenditure of funds after April 1, 1987, for preliminary plans for any project involving the construction of new or replacement beds unless the decision to proceed with construction is based on the new model.

It is the Committee's intent that the VA not expedite work on projects in order that they would not be required to be based on the new VA/GAO bed-sizing model.

Veterans' Administration Medical Facility Construction Authorization for Fiscal Year 1986

Section 411 of the Committee bill is intended to take the place of a Committee resolution under section 5004(a) of title 38 for fiscal year 1986 construction authorization proposes in light of the changes that section 401 of the Committee bill would make in the process by which appropriations for VA medical construction projects are authorized.

The Committee bill would provide a statutory limitation on the amount of appropriations that may be made in fiscal year 1986 for VA construction in the total amounts requested in the President's budget: $417.2 million for major construction projects (those costing $2 million or more) and $194.4 million for minor construction projects (those costing less than $2 million). The Committee notes that this authorization constitutes the Committee's approval of the individual medical-facility construction projects although not the amounts for them proposed by the VA in the fiscal year 1986 budget submission. It further notes that, although the amounts approved by the Committee for appropriations include amounts for other nonmedical-facility construction projects, no Committee recommendation is to be inferred in this context with respect to those appropriations.

In the cases of each of the proposed major replacement/modernization projects at three VA medical centers—Houston, Texas; Mountain Home, Tennessee; and Philadelphia, Pennsylvania—the

Committee bill would provide two specific alternative maximum amounts as authorized to be appropriated and expended (in addition to amounts previously appropriated). The first alternative amount is the full amount requested by the administration. The second alternative amount is calculated to provide for the construction of the facility at the bedsize provided for in the Committee's May 24, 1984, construction-project-approval resolution, based on a formula for reducing bedsizes that gives weighted consideration to meeting the needs of service-connected disabled veterans and financially needy veterans (see the Appendix of this report). Under the Committee bill, the first, greater amount would apply only if it is demonstrated, in accordance with the provisions of the bill, that redesigning the preliminary plans to provide for a facility of the size approved in the Committee's 1984 resolution would entail undue delay.

As noted in the discussion of section 402, above, the Committee strongly disagrees with the Administration's approach to the bedsizing of hospital facilities. In the cases of the Houston, Mountain Home, and Philadelphia projects, only the preliminary plans have been completed and the Committee continues to believe—as it did a year ago—that all reasonable steps should be taken to reduce the number of hospital beds for each. Thus, under the preferred alternative of the two alternatives adopted by the Committee, the maximum amounts that may be appropriated and expended (in addition to amounts already appropriated) for these projects would be as follows:

	Million
Houston	$170.4
Mountain Home	35.8
Philadelphia	85.6

These maximum amounts would apply unless the Administrator, within 60 days after the date of the enactment of the Committee bill, certifies that a contract for work on the physical structure or structures in which hospital care is to be provided at a bedsize level consistent with this maximum amount cannot feasibly be awarded within 180 days after (1) the date on which a contract for the construction was scheduled to be awarded as of June 1, 1985, in the case of Houston and Mountain Home, or (2) September 1, 1986, in the case of the Philadelphia project. The Administrator's certification would be required to be accompanied by the submissions of three architectural/engineering firms (the one retained by the VA to do the plans, one selected by the American Institute of Architects at the VA's request, and one selected by the Comptroller General), at least two of which support the Administrator's certification.

If the Administrator submitted the required confirming certification and supporting documentation that showed redesign of a project in question would result in undue delay, the maximum amount authorized for it would then be: $226.8 million in the case of Houston, $59.0 million in the case of Mountain Home, and $110.4 million in the case of Philadelphia. In any case, the amounts appropriated for these projects for fiscal year 1986 would have to be within the overall appropriations authorization limitation for major construction projects, described above.

In addition, this section of the Committee bill would authorize the expenditure in fiscal year 1986 of funds in the VA's major construction working reserve fund (to the extent permissible under current law as of the date the Committee bill is enacted) to redesign at the reduced hospital bedsize the Houston, Mountain Home, and Philadelphia projects as well as the following major replacement/modernization projects if the total estimated expenditure for the projects are not more than as follows:

	Million
Augusta, Georgia	$94
Baltimore, Maryland	88.8
New York, New York	70.6

The above amounts were those approved by the Committee for these projects in the Committee's May 24, 1984, resolution (less amounts already appropriated).

The Committee stresses that the project proposed for Baltimore is intended to be a replacement medical facility to be located in downtown Baltimore and that following the completion of that new facility the existing Baltimore facility (Loch Raven) would be closed.

Consideration of Planning Options To Meet Veterans Health-Care Needs

Section 421 of the Committee bill, which is derived from section 2 of S. 1007, would require the Administrator, in connection with assessing how best to meet the medical needs of eligible veterans in a particular area, to develop criteria for deciding whether to proceed with a new or replacement facility and, if so, whether to do so by construction or the purchase or lease of an existing facility—and to apply those criteria after January 1, 1986, in the consideration of, and any development of plans for, a new or replacement medical facility. The purpose of the provision is to improve the decisonmaking and planning process whereby the VA decides that a new or replacement hospital is needed and to promote fair consideration by the VA of the option of acquiring an existing medical facility by lease or purchase once it has been determined to proceed with a new or replacement facility.

Background

The Committees' strong interest in and concern about the VA's construction planning process has spanned the last three Congresses. Most recently, the Committee held 2 days of hearings on March 26 and 27, 1985, to consider certain issues pertaining to the future of the VA's construction planning process. One of the major issues addressed at the hearing was the VA's methodology for assessing various options, including construction of medical facilities, for meeting the health-care needs of eligible veterans. The Committee believes the VA should consider a wide range of treatment modalities before making a decision to build or replace the VA medi-cal facility.

In order to followup on unresolved issues at these hearings, Senator Murkowski wrote to the VA on May 6 asking a number of questions on those issues. Senator Murkowski's letter and the VA's responses follow.

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN
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United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

May 6, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry:

I am writing in follow-up to certain issues discussed during the Senate Veterans' Affairs Committee March 26 and 27, 1985, hearing on VA medical facility construction.

As Chairman, I believe the hearing provided an opportunity for the Committee to pursue certain specific areas of concern relating to the VA's construction planning process. As you know, I believe that the future direction of the VA's construction program must be examined in the context of an anticipated increased demand for services by the aging veteran population, certain policy changes proposed by the Administration pertaining to eligibility for VA medical care, and the limited availability of health care resources. VA construction program planning should, therefore, integrate certain considerations into the construction process. I urge the VA to consider the following:

First, prior to the replacement and modernization of existing facilities or the construction of new facilities, the VA should assess the feasibility of leasing or purchasing already existing private sector beds or facilities.

Second, as directed by the Committee in its views accompanying the May 24, 1984 construction resolution, the VA should modify its criteria and process for sizing VA hospitals. It is my view that in determining the size of new or replacement facilities, the VA should take into account the following factors: the percentage of service-connected veterans to be served; the availability of already existing or planned community beds; the impact of diagnostic-related groups (DRG's) on the length of stay of VA patients; and the need for and use of non-institutional forms of care.

Third, the VA should re-examine its entire construction planning process in order to reduce the time involved in the planning, design, and construction of VA medical facilities. A special effort should be made to standardize the design and components of both acute care and long-term care facilities.

I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

1. Specific information substantiating the VA's view that medical care provided by the VA is more cost-effective than medical care provided by private sector facilities;

2. A summary of existing medical programs, as documented by current MEDIPP data, for each VA medical facility and medical district and a summary of a plan for the projected medical and construction needs for each of the facilities and districts for the next 10 years taking into consideration changing needs of veterans; and

3. Criteria or standards setting forth guidelines, including those pertaining to occupancy rates, for closing entire facilities or individual programs.

With respect to requests made on March 27:

1. A copy of the results of the study by Booz Allen and the VA's plans for the implementation of Booz Allen's recommendations;

2. A list of facilities available for lease or purchase in areas where the VA has already identified a need for a new or replacement facility;

3. A list of ongoing litigation involving disputes with private contractors, change orders, architectural issues, and others;

4. Documentation relating to the need for or lack of need for VA hospital beds in the Florida panhandle/Mobile, Alabama area; and

5. Information on the percentage of veterans receiving medical care in private sector facilities and information documenting the differences in characteristics and needs of these veterans as compared to those veterans receiving care in VA facilities. Please provide a projection of any shift in care for these veterans as well as your views as to the percentage of the veteran population for which the VA should provide care.

In a related matter, as discussed at the hearing, I would urge you to engage in an open dialogue with private health care organizations, such as the Hospital Corporation of America and the American Health Care Association, for the purposes of exchanging information about VA and private sector practices relating to the planning, design, and construction of medical facilities and to work cooperatively with such organizations to attempt, on a pilot program basis, to identify cost containment and sharing innovations which would improve the efficiency and reduce the time and costs of the VA's construction planning process.

Thank you for your cooperation. I look forward to your response.

Sincerely,

Frank H. Murkowski
Chairman

Office of General Counsel Washington, D.C. 20420

Veterans Administration

JUN 5 1985

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to provide you with the Agency's responses to the questions you, Senator Stafford and Senator Denton forwarded following the Committee's March 26 and 27, 1985, hearing on VA medical facility construction.

I appreciate this opportunity to provide additional information for the record.

Sincerely yours,

DONALD L. IVERS
General Counsel

Enclosure

SENATOR MURKOWSKI

Question: 1. Specific information substantiating the VA's view that medical care provided by the VA is more cost-effective than medical care provided by private sector facilities:

Answer: The Allocation Development Service is currently preparing analyses comparing the cost of medical care in the VA system with costs in non-VA facilities. Comparisons will be based on information from the Health Care Financing Administration and from selected states and localities able to provide adequate data bases. Preliminary investigations suggest that, given its mandate to provide high-quality care to poorer and sicker patients, VA costs are comparable to those in the private sector.

SENATOR MURKOWSKI

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

2. A summary of existing medical programs, as documented by current MEDIPP data, for each VA medical facility and medical district and a summary of a plan for the projected medical and construction needs for each of the facilities and districts for the next ten years taking into consideration changing needs of veterans;

Answer: The VA, through the MEDIPP process, has estimated the needs of VA medical facilities into the future. These estimates of need have been coordinated with the VA construction planning process. Accordingly, two packages of data are provided.

First, there is included a listing based on the 1984 MEDIPP submissions which shows the actual number of VA beds and outpatient visits as of the end of Fiscal Year 1983 and the projected need for the year 1995. This listing shows data by VA medical district and by VA medical center. The results of the 1984 MEDIPP submission are in the final stages of review, so the data in this package are still subject to revision; however, it is anticipated that at this stage of the review, any changes would be minimal and not likely to affect any of the facility totals significantly.

Second, there is included a copy of the "FY 1985 - 1989 Five Year Medical Facility Construction Needs Assessment." The data in this document have been coordinated with the data from the previously approved 1983 MEDIPP submissions. This document, which is an annual submission to Congress, is currently being revised. A new "assessment" is due to Congress on June 30, 1985. The data in the new "assessment" are being coordinated with the data from the 1984 MEDIPP submissions.

Attachments

SENATOR MURKOWSKI

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

3. Criteria or standards setting forth guidelines, including those pertaining to occupancy rates, for closing entire facilities or individual programs.

Answer: The VA is giving special planning emphasis to development of actions which will enable the Agency to provide needed services within available resources. The MEDIPP guidance requires VA's medical districts to give priority attention to such actions, by conducting rigorous reassessments of district and facility missions, with a view to increasing the cost-effectiveness of services. Specifically, the districts are encouraged especially to consider actions which would:

- o consolidate facilities;
- o increase sharing and/or contracting with cost-efficient community and other resources, where to do so would be consistent with VA quality requirements;

- o eliminate less essential bed services;
- o increase use of ambulatory care and other alternatives to inpatient services; and
- o otherwise increase efficiency and productivity.

SENATOR MURKOWSKI

These efforts are intended to assure that the VA will organize and allocate its facilities and other resources in a way which will provide the best possible services to the aging veteran population over the coming years. In some cases, the termination of individual facilities or programs may be necessary to make resources available for higher priorities. Any such decisions must consider a wide variety of factors, not only current occupancy rates, workloads, and costs. They must also address demographic projections, future workloads, and various options for achieving the optimum mix, location, size and quality of services.

Given the number of variables which must be considered in each instance, the VA does not use a single set of criteria for closing facilities or programs. Instead, the VA is in the process of developing a series of specific indicators to flag programs and facilities where opportunities may exist to improve the balance of services and workloads, considering the full range of options available. These indicators are expected to be used by all levels in the Department of Medicine and Surgery to identify and evaluate opportunities and recommendations for such improvements during the planning process.

SENATOR MURKOWSKI

Indicators under staff consideration at this stage relate to occupancy rates, demographic and workload projections, costs per unit of workload, case mix trends, facility condition, and the geographical distribution of programs. When the list of indicators is approved, we would expect the districts to propose an appropriate mission or operating change for each facility or program which exhibits a significant number of indicators, or else to present convincing justification as to why no such change is needed. These indicators will be an important factor in Regional and Central Office reviews of district plans.

When the list of program review indicators is completed by late summer, we will be glad to share them with the Committee.

49-326 O—85——4

SENATOR MURKOWSKI

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 27, please submit the following information:

1. A copy of the results of the study by Booz Allen and the VA's plans for the implementation of Booz Allen's recommendations.

Answer: The Administrator's policy is to transmit the report after he has had an opportunity to study it thoroughly and to make his decision on the recommendations he will implement. The Administrator requested and received a briefing on the study's findings on the day the study was completed. Department and staff offices are now reviewing the report and we anticipate a decision soon from the Administrator. Thereafter, a plan for implementing the recommendations will be developed. We shall then provide you with a copy of the Booz Allen study and the plan for implementation and/or brief you at that time.

Senator Murkowski:

I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 27, please submit the following information:

3. A list of ongoing litigation involving disputes with private contractors, change orders, architectural issues, and others;

Answer:

See the attached Quarterly Report of the Board of Contract Appeals and the Contract Appeals Board dated April 12, 1985.

Attachment

Veterans Administration

Memorandum

Date: April 12, 1985

To: Deputy Administrator (001)

From: Board of Contract Appeals (09)

Subj: Quarterly Report of Board of Contract Appeals (BCA) and Contract Appeals Board (CAB)

1. Caseload summary for the quarter ending March 31, 1985:

(a) Appeals pending at beginning of quarter	260
(b) New cases docketed	58
(c) Appeals reinstated	3
(d) Cases disposed of (listed separately by docket number beginning on p. 50)	39
(e) Appeals pending at end of quarter	282

2. Distribution of pending appeals:

Contract Type	Station Level		Central Office		Total	Percentage of Pending Appeals
Construction	189	+	64	=	253	90%
Supply	7	+	1	=	8	3%
Service	20	+	1	=	21	7%
Total	216	+	66	=	282	100%

3. Attached is pertinent data (including the status) of each case on the BCA/CAB docket as of March 31, 1985 (Section I), and of each case disposed of during the quarter (Section II).

JOHN J. CORCORAN
Chairman

Att:

VA FORM 2105
MAY 1983
U.S. GOVERNMENT PRINTING OFFICE: 1984-421-488/0348

SENATOR MURKOWSKI

Question: I am also writing to reiterate my request, made at the hearing, for certain information related to the provision of medical care by the VA and the VA's construction program. With respect to my requests made on March 26, please submit the following information:

4. Documentation relating to the need for or lack of need for VA hospital beds in the Florida panbhandle/Mobile, Alabama area;

Answer: The issue of the need for or lack of need for a VA hospital in Mobile, Alabama or the Florida panhandle has been extensively analyzed and reviewed. The attached papers contain the documentation which supports the decision of the Veterans Administration to place a VA hospital in the Florida panhandle in Okaloosa County (Attachment).

[The attachments referred to above may be found in the Committee's files.]

QUESTION

5. Information on the percentage of veterans receiving medical care in private sector facilities and information documenting the differences in characteristics and needs of these veterans as compared to those veterans receiving care in VA facilities. Please provide a projection of any shift in care for these veterans as well as your views as to the percentage of the veteran population for which the VA should provide care.

ANSWER

Two sources of data are particularly relevant in estimating the percentage of veterans receiving care in VA facilities versus the percentage receiving care in Non-VA facilities and in describing differences between these two populations. These are the 1979 National Survey of Veterans and the Health Interview Survey conducted at regular intervals by the National Center for Health Statistics. These Sources point out that approximately 12% of veteran discharges are from VA facilities. They also point out that veterans receiving care at VA facilities tend to be older, have lower incomes, and suffer from certain conditions to a greater degree than veterans receiving care in Non-VA hospitals. The surveys indicate that a higher percentage of veterans receiving care at VA facilities are in the 45-54 and 55-64 age groups, for example. Also, nearly 60% of those seen at VA medical centers had low family incomes (under $10,000) compared to less than 20% of those discharged from Non-VA hospitals. Although care at VA facilities accounted for only 12% of total veteran discharges, VA care for mental and personality disorders

accounted for 29% of veteran discharges in this are; VA care for malignant neoplasms (cancer) accounted for 18% of all veteran discharges for this condition; and VA care for chronic respiratory conditions accounted for 17% of veteran discharges during the period of the surveys. In summary, veterans receiving care at VA facilities are concentrated in older age groups, are poorer, and suffer from more chronic conditions than veterans receiving care in private sector hospitals.

The planning process the Department of Medicine and Surgery uses does not project any shift in care from what is presently provided. A four-year historical trend is projected forward to the 1990-2000 planning horizon with adjustments made for the increased aging of the veteran population. The percentage of eligible veterans that find health care attractive from the VA may be effected by a number of external influences, one of those being changes in Medicare eligibility or co-payment. The VA cannot either control nor project such changes, therefore, planning for the future must be based on historical trends.

The Committee continues to believe that there should be greater coordination between those in DM&S who are involved in assessing the needs of eligible veterans for health care and those responsible for the construction planning process.

The Committee urges the VA to consider the following issues prior to the decision to replace or construct a VA medical facility: (1) could the needs of eligible veterans in the catchment area be met through action other than building or acquiring a medical facility; (2) what will be the future needs of such veterans over the next 10 years as compared to their historical needs and usage of VA services; (3) how do changes in medical care, including advances in medical technology, affect the need to provide inpatient service; (4) to what degree should a medical school affiliation affect a decision to construct a hospital; and (5) how might recent policy proposals, if implemented, such as the means test and third-party reimbursement proposal, affect veterans' demands for health care as well as the configuration of the VA health-care system?

This provision in the Committee bill is designed to ensure that these very important concerns are addressed and that the VA can demonstrate that construction projects are proposed only after a thorough review of all these questions has been made.

Once a need to construct is established, the Committee believes, based partly on testimony given at hearings in the 98th and 99th Congresses, that the VA generally gives only scant consideration to options other than construction for providing new or replacement medical facilities. In the Committee's view, there may be instances in which the purchase or lease of an existing facility, as compared to new construction, could result in substantial cost savings and enhance or have no adverse impact on the quality of care or its accessibility to veterans in the geographic area involved. Thus, these provisions are designed to foster and require the development of standard criteria for, and the applications of them to, the consideration of purchase and lease alternatives by the VA.

Committee bill

Under the Committee bill, effective January 1, 1986, the Administrator would not be permitted to proceed with the development of plans for a new or replacement facility without applying the criteria developed by the VA and without considering the options of purchasing or leasing an existing medical facility that meets certain requirements set forth in the Committee bill. Under those requirements, an existing available facility would have to be considered for purchase or lease if it meets certain cost limitations and either meets or could be adapted to meet the current and projected needs and specifications of the VA in providing health-care services to eligible veterans residing within a 100-mile radius of where the new or replacement facility would otherwise be located. The cost limitations would be that the cost of acquiring the existing facility, together with the cost of any necessary adaptations, could not exceed the estimated operating costs of a newly-built facility.

The Committee bill would also require the Administrator, when submitting to the Committees on Veterans' Affairs of the House and the Senate (as required by section 5004(d) of title 38), a prospectus for a new or replacement medical facility, to include in the

prospectus a description of the consideration that had been given to the option of purchasing or leasing an existing facility.

In this connection, the Committee wishes to emphasize that it does not disfavor the option of renovating or otherwise altering existing VA facilities. Rather, the Committee intends that, once it has been determined that new or replacement beds are needed, the criteria to be established for determining whether to proceed with a new or replacement hospital project must require full and fair consideration of the cost-effectiveness of renovating any existing VA facilities.

Contract for Construction and Operation of a Nursing Home

Background

During the past few years, the Committee has raised questions about the VA's practices with respect to the construction and operation of nursing home care units. At the center of the controversy have been the questions as to why the VA's nursing home construction and operating costs seem considerably higher than those in the private sector. The assertion has been made (by the Grace Commission and an association representing proprietary nursing homes among others) that private sector firms could provide equivalent facilities and services at lower costs.

In the Committee's view, whether a private firm could actually build and operate a VA nursing home care unit (NHCU) at less cost to the agency than if the VA were to contract for the construction of the facility and itself operate it, as under current practices, is an open question and will likely remain so until such time as the private-sector approach is tested.

Committee bill

Thus, in order to provide a realistic basis for providing a comparison, section 422 of the Committee bill, which is derived from section 3(c)(2) of S. 1007, would require the Administrator to enter into a contract with an appropriate entity for the construction at VA expense as well as for the operation—for the 5-year period following completion of construction and, at the VA's option, for an additional period of up to 5 years—of a nursing home meeting the needs and specifications of the VA. These needs and specifications would include matters relating to the location of the facility in close proximity to a VA medical center in order to assure reasonable access to medical care, relating to the physical structure of the NHCU, and relating to the quality and quantity of nursing home care services at the facility.

Certain matters required to be specified in the contract are set forth in the Committee bill. Thus, the contract would have to require that the nursing home be staffed and operated in a manner so as to provide the type or types of care that would be provided if the facility were being operated by the VA. Also, the VA would have to be required by the contract to refer a sufficient number of veterans to ensure a specific occupancy rate—at least approximately equal to the nationwide average for VA nursing homes—and the per-diem rate payable to the contractor could not exceed the average daily costs to the VA of operating its own nursing home care

facilities. Non-veterans would not be eligible for care in this facility. In addition, the Administrator would be required to include such other contract provisions as are determined to be in the best interests of the Federal Government.

The Committee stresses that this provision does not in any way permit any failure to comply with labor and other Federal requirements (such as Davis-Bacon Act requirements) applicable to Federal Government contracts for the construction of buildings or applicable to Federal contractors and subcontractors.

It is the Committee's hope that this provision will help resolve some of the questions and controversy surrounding the VA's nursing home care program and may, perhaps, offer some guidance in terms of future policy decisions.

The VA, in its June 12, 1985, letter to the Chairman, transmitting the agency's views on S. 1007, expressed its opposition to section 3 of that measure, noting that it does not believe it "offers a satisfactory methodology for testing" this approach and that the information that the pilot program would produce "is unlikely to provide a meaningful basis for determining the most cost-effective means of acquiring medical facilities." In addition, it raised concerns about a number of ambiguities regarding specific provisions of section 3 of S. 1007—such as the issues of non-veteran patients, Davis-Bacon Act requirements, and VA per-diem payment rates. These issues were all addressed in modifications reflected in the Committee's bill. The full text of the VA's June 12 letter is reprinted later in this report.

Feasibility Plan for the Purchase of a Facility for Furnishing Hospital and Nursing Home Care

As noted previously in connection with the discussion relating to section 421, the Committee is concerned that the VA too often fails to consider options other than construction when considering the need for new or replacement medical facilities. As discussed above, the provisions of section 421 of the Committee bill would establish a procedure to ensure that consideration is given to the option of leasing or purchasing existing medical facilities that meet the current and future needs and specifications of the VA.

In addition, section 423 of the Committee bill, which is derived from sections 3(c)(3) and 6 of S. 1007, would require the Administrator to submit, in connection with the submission of the President's budget for the Federal Government for fiscal year 1987, a feasibility plan for the purchase of a medical facility, located in an urban area, that is suitable to provide both hospital and nursing home care and meets the VA's current and projected needs and specifications in providing health care to eligible veterans. The Committee notes that the VA's needs and specifications would include identification of the catchment area where the services of the new facility are needed.

Further, section 423 of the Committee bill would require the President, consistent with the results of the feasibility plan, to include in the VA's fiscal year 1987 budget a request for an appropriate amount for the purchase of such a hospital/nursing home facility which meets the VA's needs and specifications. The Committee

intends that the VA carefully consider the Providence Hospital in Mobile, Alabama, as the subject for the feasibility plan required by this provision.

The VA, in a June 12, 1985, letter to the Chairman, expressed a number of reservations about this and various other provisions in S. 1007. In consideration of these reservations, the Committee has adopted this feasibility study approach.

Development of Hospital Modular Components

Section 424 of the Committee bill would require the VA to enter into a contract for the development of a modular approach to use for the planning and design of a VA hospital in order to evaluate the applicability and cost-effectiveness of this approach and its use in the VA's design and construction process. The Committee expects that the use of such an approach would give the VA an opportunity to evaluate its usefulness.

The Chairman, as part of the hearings held on March 26, and 27, 1985, on VA medical facility construction, discussed the use of modular components (such as for a standard hospital room, an operating suite, and a coronary care unit, for example) as a means of providing quality VA health care to eligible veterans in the most cost efficient fashion. The Committee believes that the adoption of such an approach in VA hospital construction could result in a reduction in the time required to plan and design a hospital and in reduced expenditures throughout the construction process. Thus, it considers the use of modular components an important option that should be pursued through development, use, and evaluation of such an approach as provided for in the Committee bill.

The Committee notes that this modular approach has been applied by the VA to the design of a prototype VA nursing home and that the VA estimates that this approach (which incorporates a total modular concept rather than components) will save more than $300,000 per VA nursing home care unit constructed. The computerized prototype is anticipated to be completed and used in VA nursing home construction projects initiated in fiscal year 1987.

Tom Batey, Vice President, Planning and Construction, and O. David West. Ph.D., Director Special Projects, representing the Hospital Corporation of America (HCA), in testimony presented to the Committee at its March 27, 1985, hearing on VA medical facility construction, provided information about certain hospital cost containment measures, including the use of modular components, employed by HCA. In a May 29 letter to VA Administrator Harry Walters, Dr. West proposed that HCA and the VA work in cooperation to identify cost containment and sharing innovations that would be mutually beneficial to the VA, the private sector, and the veteran. The Committee believes that cooperative efforts between the private sector and the VA should be explored generally and especially with respect to the development of a modular approach.

Technical, Conforming Amendment Relating to the Continuing Availability of Readjustment Counseling

Section 501 of the Committee bill, which is derived from Amendment No. 22 to S. 6, is a technical, conforming amendment to section 612A(g)(1)(B) of title 38, relating to the VA's responsibility during the 12-month period ending September 30, 1988, for planning for the continued availability of readjustment counseling and related mental health services for Vietnam-era veterans. This amendment conforms subsection (b)(1)(B) of section 612A to subsection (a) of that section by deleting a reference to a date by which veterans would have to request readjustment counseling in order for the Administrator to be required to take them into account in the planning required by section 612A(g)(1). By this change, the planning requirement in section 612A(g)(1) would be conformed to the ongoing counseling eligibility provided for in section 612A(a) as that section was amended in 1983 by section 101 of Public Law 98–160.

Payments for Therapeutic and Rehabilitation Activity

Section 502 of the Committee bill, which is derived from section 6 of S. 6, would provide that any remuneration received by VA patients as a result of their participation in a rehabilitation therapy program under section 618 of title 38 would not be counted as income for the purpose of VA pension programs.

Background

A similar provision was reported by the Committee during the last Congress as section 14 of S. 2514 and passed by the Senate on October 21, 1984, as part of H.R. 5688. However, that provision was not included in the compromise agreement reached with the House of Representatives on that legislation and enacted as Public Law 98–543.

Under section 618 of title 38, United States Code, the VA operates, in the Department of Medicine and Surgery, therapeutic and rehabilitation programs under which VA patients—either inpatients, residents in domiciliary facilities, or outpatients—selected for such programs perform services for which they receive a small payment. These programs are known commonly as incentive therapy (IT) and compensated work therapy (CWT) programs.

According to the VA, participants in IT programs are assigned duties within the treating VA medical center or domiciliary as patient messengers, grounds workers, and building management assistants and paid out of appropriated funds hourly wages ranging from a nominal amount to half the minimum wage. Patients in CWT programs, according to the VA, learn work habits and/or vocational skills by working on projects under VA contracts with private industry or other sources and are paid wages by the private entity under those contracts commensurate with wages paid in the community for work of the same quality and quantity. Both programs are designed to promote self-sufficiency in the participants by developing increased feelings of self-worth and socialization

skills, prevention of depression and regressive behavior, and acquisition of pre-vocational skills in order to reduce dependence on long-term VA hospitalization and other support from Federal, State, and local government sources.

In response to questions submitted to the VA following the Committee's April 11 hearing last year, the VA indicated that 85 VA facilities then had IT programs and 40 facilities had CWT programs. In 1983, 30,347 veterans participated in IT programs and 7,250 veterans participated in CWT programs. In fiscal year 1984 24,923 veterans participated in IT programs and 6,469 veterans participated in CWT programs.

In 1983, the VA's Inspector General conducted an audit (IG Audit Report No. 3R3-B02-066, March 31, 1983) that indicated that many veterans participating in CWT programs who were also in receipt of VA pension were not reporting income received from their participation in CWT programs. In response to that report, the VA's Department of Medicine and Surgery instituted a program of income verification pursuant to which VA medical facilities, effective approximately January 1, 1984, began to inform appropriate VA regional offices of the Department of Veterans' Benefits of the amounts paid to veteran participants in the IT and CWT programs.

Committee bill

Section 502 of the Committee bill would thus amend section 618 of title 38 to provide expressly that remuneration received by veterans as a result of their participation in IT or CWT programs would not be counted as income for the purpose of VA pension programs. The Committee is taking this action in response to the record before the Committee, both last year and during the current session, which suggests that counting such remuneration as income for pension purposes is acting as a significant disincentive to veterans' participation in these two programs which, in turn, is having an adverse effect on their successful rehabilitation. In this regard, a Medical Center Director in a letter to the Committee's Ranking Minority Member which was reprinted in the report accompanying S. 2514 last year (S. Rept. No. 98-487, page 70) noted that, of an original group of 39 patients in IT/CWT programs at his facility when the practice of reporting income was initiated, 31 patients left the program and all cited the change in how their remuneration was counted as their reason for leaving.

The Committee notes that the General Accounting Office is nearing completion of a study and report on this issue and that the preliminary results of that study are consistent with the fragmentary information received by the Committee last year—that is, that at the facilities surveyed large numbers of veterans had withdrawn from IT/CWT programs.

Report on Federal Government Responsibility to Individuals Who Served with Voluntary Civilian Organizations in Vietnam

Section 503 of the Committee bill, which is derived from section 10 of S. 6, would require the Secretary of Defense, the Secretary of Health and Human Services, and the Administrator of Veterans' Affairs to submit to the Congress a joint report evaluating the

question of United States Government responsibility, and alternative approaches, for providing Federal and other benefits, services, and assistance relating to disabilities that possibly resulted from certain aspects of service in Vietnam—such as exposure to Agent Orange or to particularly traumatic events—to individuals who were present there during the Vietnam-era as civilian employees or as volunteers serving under the auspices of voluntary organizations.

Background

A nearly identical provision was reported by the Committee during the last Congress as section 12 of S. 2514 and passed by the Senate on August 9, 1984, as part of H.R. 5618. However, that provision was not included in the compromise agreement reached with the House of Representatives on that legislation and enacted as Public Law 98-528.

Since questions relating to the health effects in veterans of exposure to Agent Orange first came to national attention in 1977, the Committee has produced several major legislative initiatives and has engaged in rigorous oversight both of the VA's efforts to address veterans concerns on this issue as well as of the progress of the scientific studies relating to this matter. In this connection, the Committee has held five major hearings related to Agent Orange and has developed three major legislative initiatives enacted into law on the issue: First, in 1979, mandating a large-scale epidemiological study of Vietnam veterans (section 307 of Public Law 96-151, later modified by Public Law 97-72); second, in 1981, providing authority for the VA to furnish health care for veterans exposed to Agent Orange (section 102 of Public Law 97-72); and, third, most recently with the enactment in 1984 of Public Law 98-542 which addressed the need for compensation standards.

In connection with these efforts relating to veterans who served in Vietnam, it has come to the Committee's attention that a number of the non-Federal civilians who served in Vietnam with voluntary organizations during the Vietnam era—such as the Red Cross and U.S.O.—and provided significant assistance to the U.S. Armed Forces share many of the veterans concerns about the effects of their service there. The Committee is concerned that former employees of these organizations (as well as volunteers associated with the organizations) were potentially exposed to many of the same environmental situations and shared many of the experiences of the members of the Armed Forces. These individuals have noted that, because so much of the Federal Government's efforts to respond to concerns regarding the possible long-term health effects of serving in Vietnam have involved an agency uniquely devoted to veterans (the VA), they have been excluded from this process and any access to health care or compensation that it might yield.

Committee bill

In view of the contribution that these individuals made to their country and their concerns about the long-term health effects of their Vietnam service that may be related to actions by the Federal Government, the Committee believes that the Federal Government should evaluate the question of Federal responsibility and

possible appropriate alternatives—Federal and non-Federal—for addressing such concerns. The Committee bill is designed to bring about that evaluation.

At the Committee's May 7 hearing, the VA testified in opposition to this provision noting, among other reasons, the view that the agency did not believe "it would be prudent to expend funds of the United States Government to conduct an extensive study on a potential problem where there appears to be little evidence that a real problem exists." In response to a question on this point from Senator Cranston, however, the VA was unable to provide any estimate of the cost of developing the report.

The Committee notes, as to another point raised by the VA, that the report requirement in no way is intended to prejudge the question of Federal responsibility for assistance or to reflect a judgement by the Committee regarding the military or non-military status of any group of civilians who served in Vietnam for the purposes of receiving veterans benefits. A mechanism, the Department of Defense/Civilain Military Review Board, established pursuant to section 401 of Public Law 95–202, already exists to weigh evidence and pass judgement as to whether a particular civilian groups' service to the country during a period of war was such that it should be considered military service for the purpose of receiving veterans benefits. Section 503 of the Committee bill is not designed to circumvent or influence this separate avenue of redress. Rather, the Committee views the issue presently before it—the question of the extent to which the Federal Government may be responsible to these individuals and the need for an evaluation of alternatives for providing an avenue of redress for them if necessary—as entirely separate from the issue of veteran status.

Land Transfer, Phoenix, Arizona

Section 504 of the Committee bill would require the transfer of, without reimbursement, a 3.25-acre site (and the structures thereon) adjacent to the VA Medical Center in Phoenix, Arizona, from the control and jurisdiction of the General Services Administration (GSA) to the control and jurisdiction of the VA.

Background

This site was part of a parcel of 27 acres transferred to the VA in 1947 for the construction and operation of a VA medical facility. In 1959, the VA declared the 3.25-acre site as excess to its needs and conveyed it to the GSA. In 1961, approximately half of the 3.25-acre parcel was transferred to the Department of Health and Human Services (HHS, then known as the Department of Health, Education, and Welfare) for use by the Centers for Disease Control (CDC). In 1962, the GSA sold the balance of the parcel to a private developer under deed conditions providing that the developer would construct buildings suitable for the use of the CDC and, at the end of the 20-year lease period, would, at the Government's option, sell the property back to the Federal Government for $1 for the buildings plus the fair market value of the land.

In 1983, pursuant to the option in the lease, HHS purchased the land from the developer for the fair market value of $643,000 and

the buildings for $1. In November 1984, HHS declared the entire parcel of the land excess and it reverted to GSA.

The VA has developed a conceptual plan of use for the property, which has an estimated fair market value of approximately $2 million. Under this plan, functions not critical to patient care—such as Supply, Fiscal and Personnel Service, Medical Administration, and Warehousing functions—would be relocated in the structures on the parcel and the additional land would be used to alleviate parking problems at the medical center.

It is the Committee's understanding that the VA has submitted a report to GSA setting forth its need for the site, requesting its return and, in do doing, noting its intention to request a waiver from OMB of the current policy that would require the VA to pay GSA the full fair market value of the land.

Committee bill

Without addressing the validity of this policy in general, the Committee believes that in this case—in which the property was previously under the control and jurisdiction of the VA, which had transferred it to GSA without any remuneration and in which the buildings were transferred to the Government at no cost and, in any event, not paid for by the GSA—to require the VA to pay GSA the fair market value of the real estate would be totally inappropriate. The Committee bill would thus direct the transfer of the land and buildings to the VA at no cost to the VA.

Cost Estimate

In compliance with paragraph 11(a) rule XXVI, of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office, estimates that the costs resulting from the enactment of the Committee bill during the first 5 years following enactment would be $74 million in fiscal year 1986; $173 million in fiscal year 1987; $221 million in fiscal year 1988; $166 million in fiscal year 1989; and $61 million in fiscal year 1990. A detailed breakdown of the costs, as estimated by CBO, over the 5-year period follows:

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 2, 1985

1. BILL NUMBER: S. 876

2. BILL TITLE:

Veterans Administration Health-Care Programs Improvement Act of 1985.

3. BILL STATUS:

As ordered reported by the Senate Committee on Veterans' Affairs, June 12, 1985.

4. BILL PURPOSE:

To establish, extend, and improve certain Veterans Administration (VA) health-care programs.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Budget Authority	628	40	57	53	4
Outlays	74	173	221	166	61

The cost of this bill would fall in budget function 700.

Basis for Estimate:

The following section-by-section cost analysis only addresses those sections of the bill that could be expected to have a significant budgetary impact.

Section 101: This section would authorize the VA to conduct a three-year pilot program, under which ten readjustment counseling centers would be designated Vietnam Veterans Resource Centers. These centers would coordinate the provision of a variety of benefits and services available to Vietnam veterans under current law. The pilot program would begin January 1, 1986, and would extend through December 31, 1988.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Estimated Authorization Level	1	1	1	*	0
Estimated Outlays	1	1	1	*	0

* Less than $500,000.

This provision would not enlarge upon the scope of benefits available to Vietnam veterans. The estimate assumes that three additional employees, on the average, would be required in each participating center. The average grade level of these employees was assumed to be GS-7.

Section 102: This section would authorize the VA to establish a pilot program of community-based psychiatric residential treatment for chronically mentally ill veterans. To be eligible for participation in the pilot program, a veteran must be receiving care (other than outpatient care) from the VA for a service-connected chronic mental disability, or, if the veteran's chronic mental disability is not service-connected, he must have other service-connected disabilities rated 50 percent disabling or greater. The pilot program would be operated during the period of January 1, 1986 through December 31, 1989.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Estimated Authorization Level	6	10	10	11	3
Estimated Outlays	6	10	10	11	3

The language of the bill gives no indication as to the intended scope of the pilot program. This estimate assumes that the program would be set up in a manner similar to the pilot program of community residential care for alcohol and drug abuse disorders.

However, since psychiatric residential treatment is generally more costly than alcohol and drug abuse treatment, the estimated cost of the proposed pilot program is correspondingly higher than the cost of the alcohol and drug abuse pilot program.

Section 103: This section would authorize the VA to conduct a pilot program to provide non-institutional alternatives to hospital and nursing home care. The pilot program would be conducted in ten VA facilities, and its cost would be financed from funds appropriated for intermediate hospital care. The pilot program would be conducted from January 1, 1986 through December 31, 1989.

The budgetary impact of this provision would depend on the status of the veterans--i.e., currently in VA nursing homes, occupying intermediate care beds while awaiting a nursing home vacancy, not currently receiving VA care, etc.--selected to participate in the pilot program. According to VA data, the 1984 average cost per patient treated in a VA nursing home bed was $20,806 and in an intermediate care bed was $15,242. If the cost of non-institutional care is limited to 60 percent of the cost of nursing home care (.60 x $20,806 = $12,484), the average cost of non-institutional care would be less than the cost of either nursing home or intermediate care. Thus, if all the program participants were receiving intermediate or nursing home care before joining the pilot program, a net cost savings would result.

If, however, participants were selected who would not be receiving care at all from the VA in the absence of the pilot program, a significant reduction in the financing of intermediate care could be required to fund the pilot program. For the purpose of this estimate, it was assumed that the VA would select a mix of participants such that neither a budgetary savings nor a reduction in the provision of intermediate care would result.

Section 104: This section would authorize the VA to conduct a pilot program for the provision of chiropractic services to certain veterans for neuromusculoskeletal conditions of the spine. The program would be conducted from January 1, 1986 to December 31, 1988, and expenditures would be limited to not more than $2 million in any fiscal year.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Authorization Level	2	2	2	1	0
Estimated Outlays	2	2	2	1	0

The authorization level is based on the maximum expenditures allowed under the provision. Outlays were estimated according to historical spending patterns.

Section 202: This section would extend through 1989 the authority of the Administrator to provide medical care to veterans exposed to ionizing radiation or toxic substances while in service. The sunset date for the current authority, which is tied to the submission by the VA of a report to the Congress, is expected to be in February 1987.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Estimated Authorization Level	0	20	37	40	0
Estimated Outlays	0	20	37	40	0

According to the VA, approximately $37 million was spent in fiscal year 1984 to provide medical care to veterans exposed to toxic substances during service in Vietnam and $0.5 million for veterans exposed to ionizing radiation. This estimate assumes that a similar number of veterans would apply for care during the extension period and that the average cost of care would rise at the same rate as the Consumer Price Index for Medical Services.

The estimate further assumes that 25 percent of the toxin-exposed veterans and 70 percent of the radiation-exposed veterans would be eligible for care under other provisions of Title 38 (U.S.C.) if the special authority were allowed to expire.

Section 204: This section would extend for three years the authority of the VA to provide treatment for alcohol and drug abuse disorders in community treatment facilities. The current authority expires on September 30, 1985.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Estimated Authorization Level	6	6	6	0	0
Estimated Outlays	6	6	6	0	0

In fiscal year 1985, $6.1 million was appropriated for this activity, and the same amount has been requested for 1986. Since the VA maintains that they have no plans to expand the current scope of the program, this amount, adjusted for inflation, was assumed to be appropriated in each year of the extension period. Outlays were estimated according to historical spending patterns.

Section 411: This section would authorize the appropriation in fiscal year 1986 of $417.2 million for the Construction, Major Projects account and $194.4 million for the Construction, Minor Projects account.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Construction, Major Projects					
Authorization Level	417	0	0	0	0
Estimated Outlays	10	75	125	83	42
Construction, Minor Projects					
Authorization Level	194	0	0	0	0
Estimated Outlays	48	58	39	29	16
Total 1/					
Authorization Level	612	0	0	0	0
Estimated Outlays	58	133	164	113	57

1/ Detail may not add to total due to rounding.

The authorization levels specified in this section are equal to the budget authority levels assumed for these accounts in Senate-passed S. Con. Res. 32, the First Concurrent Resolution on the Budget for Fiscal Year 1986. The outlays were estimated according to historical spending patterns. Since both the Major Projects and Minor Projects accounts display spending patterns that exceed five years in duration, additional outlays from these authorizations would occur after 1990.

Section 422: This section would require the Administrator to enter into a contract with a private organization for the construction and operation of a nursing home for the VA.

This provision would probably result in some cost savings if the contract for construction and operation of a nursing home is in lieu of VA construction and operation of a home. However, since only one nursing home would be involved, it is not expected that the budgetary impact in any one year would be significant.

Section 423: This section would require the VA to develop a feasibility plan for the purchase of a medical facility for operation by the agency. The VA would also be required to include purchase cost of such facility in the agency's 1987 appropriation request.

Since none of the details of the required purchase can be foreseen at this time, it is not possible to estimate with any precision the likely budget impact of this provision.

Section 502: This section would provide that certain income paid to veterans as participants in therapeutic and rehabilitative work programs would not be counted as income for the purposes of calculating VA pension benefits.

(By fiscal years, in millions of dollars)

	1986	1987	1988	1989	1990
Budget Authority	1	1	1	1	1
Estimated Outlays	1	1	1	1	1

Data are not available with which to determine the number of veterans participating in VA-sponsored work rehabilitation programs who are also receiving pensions. It was assumed, therefore, that one-half of the obligations of the Special Therapeutic and Rehabilitative Activities Fund would be paid to veterans receiving pensions. Since pension benefits are reduced dollar-for-dollar for outside income, costs equal to these obligations would accrue to the pension program as a result of this provision.

Section 504: This section would require that certain real property in Phoenix, Arizona be transferred without compensation or reimbursement from the jurisdiction of the General Services Administration (GSA) to the jurisdiction of the VA.

The property addressed by this section was declared to be in excess of the needs of the VA in 1959 and was transferred to the GSA. The VA is currently negotiating with the GSA to repurchase the property, which has been appraised at approximately $2 million. Enactment of this provision would result in a savings to the VA of the purchase price of the property, but this savings would be offset by an equivalent cost to the GSA. Thus, the measure would have no net budgetary impact.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS:

The Congressional Budget Office has determined that the budgets of state and local governments would not be directly affected by enactment of this bill.

7. ESTIMATE COMPARISON: None.

8. PREVIOUS CBO ESTIMATE:

An estimate was provided by CBO on June 14, 1985, of a version of S. 876 that was understood to be final. Since that date, certain changes have been made to the bill. The primary change was a reordering and renumbering of the sections of the bill. The estimate above reflects these changes.

9. ESTIMATE PREPARED BY: K.W. Shepherd (226-2820).

10. ESTIMATE APPROVED BY:

James L. Blum
Assistant Director
for Budget Analysis

Regulatory Impact Statement

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The results of that evaluation are described below.

The Committee bill would improve and extend certain VA programs of benefits and services, improve the management of the VA's health-care system, and make various improvements in the VA's medical-facility construction and acquisition programs. Thus, the Committee finds that the Committee bill would not entail any significant regulation of any individuals or businesses or result in any significant impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

Section-by-Section Analysis of S. 876 as Reported

Section 1—Short Title

Subsection (a) of section 1 would provide that this measure may be cited as the "Veterans' Administration Health-Care Programs Improvement Act of 1985".

Subsection (b) of section 1 would provide that, except as otherwise provided, whenever in the Committee bill an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section

or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Codes.

TITLE I—PILOT PROGRAMS

Section 101

Would amend present section 612A of title 38, United States Code, relating to Vietnam-era readjustment counseling and related mental-health services to Vietnam-era veterans to add a new subsection (h), as follows:

Paragraph (1) of new subsection (h): Would require the Administrator to conduct a 3-year (calendar years 1986–88) program under which the VA at 10 readjustment counseling facilities (Vet Centers), designated as Vietnam Veteran Resource Centers (VVRC's), would provide and coordinate the provision of certain additional services (as described in paragraph (2) (discussed below) of this new subsection) in order to evaluate the effectiveness, feasibility, and desirability of providing these services in this fashion to vietnam-era veterans eligible for readjustment counseling under present section 612A.

Paragraph (2) of new subsection (h): Would specify that the additional services that would be required to be provided to eligible Vietnam-era veterans, and to be coordinated for them, under the pilot program would be (1) counseling with respect to all VA benefits and services for which the veterans may be eligible, together with assistance in applying for those benefits; (2) employment counseling, training, placement, and related services described in sections 2003 and 2003A of title 38, relating to certain veterans' employment programs, or provided under other laws administered by the Secretary of Labor; (3) initial intake and referral services with respect to alcohol or drug dependence or abuse disabilities and followup services for veterans who have received treatment for such disabilities; and (4) assistance in coordinating the services provided under the pilot program and other veterans' benefits and services provided by the VA, the Department of Labor, or any other Federal agency or official.

Subparagraph (A) of paragraph (3) of new subsection (h): Would require the Administrator, in order to carry out the mandated pilot program, to designate as demonstration projects 10 facilities which, on the date of the enactment of this new section, are providing readjustment counseling (Vet Centers). These facilities would, for the duration of the pilot program, be known as VVRC's. In addition, the Administrator would be required to provide to each of the [VVRC's] the additional staff and other resources necessary for it to provide the services (except those related to employment assistance) described in paragraph (2) (discussed above) of the new subsection and to notify the Secretary of Labor of the need to assign personnel to the VVRC's to provide the employment assistance services described in that paragraph.

Subparagraph (B) of paragraph (3) of new subsection (h): Would make the Administrator responsible for coordinating the assignment and use of employees, on a full- or part-time basis as appropriate, in the VVRC's and require the Administrator, in fulfilling that responsibility, to make maximum feasible use of the VA per-

sonnel who were employees at each Vet Center on the date each Center was redesignated as VVRC. The Secretary of Laor would be responsible for the assignment to each VVRC, on a full- or part-time basis as appropriate, of a disabled veterans' outreach specialist (appointed pursuant to section 2003A of title 38) or local veterans' employment representatives (local employment office staff members assigned to veterans' employment assistance programs pursuant to section 2004 of title 38).

Subparagraph (A) of paragraph (4) of new subsection (h): Would require the Administrator—in order to ensure appropriate coordination, direction, implementation, and assessment of the pilot program established under this new subsection—to establish and provide support for a VVRC Coordinating Committee (hereinafter in the discussion of this new subsection referred to as the "Coordinating Committee") with membership as described in subparagraph (B) of this paragraph (discussed below) of the new subsection.

Subparagraph (B) of paragraph (4) of new subsection (h): Would specify that the membership of the Coordinating Committee would be composed of one or more members appointed by and representing each of the following VA officials: The Administrator, the Chief Medical Director, and the Chief Benefits Director; and one member appointed by and representing the Assistant Secretary of Labor for Veterans' Employment.

Subparagraph (C) of paragraph (4) of new subsection (h): Would require the Coordinating Committee, first by June 30, 1986, and then not less often than every 6 months thereafter, to report to the Administrator, the Chief Medical Director, the Chief Benefits Director, and the Assistant Secretary of Labor for Veterans' Employment on the implementation and status of the pilot program.

Paragraph (5) of new subsection (h): Would authorize the Administrator, once the Coordinating Committee is established pursuant to paragraph (4) (discussed above) of this new subsection, to delegate to the Chief Medical Director the responsibility for carrying out the pilot program.

Subparagraph (A) of paragraph (6) of new subsection (h): Would require the Administrator, not later than April 1, 1987, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the experience under the pilot program during the first 15 months of the program. The report would be required to include the Administrator's assessment of the effectiveness of the pilot program in providing and coordinating the provision of the services described in paragraph (2) (discussed above) of this new subsection and the readjustment counseling and related mental health services furnished under present subsections (a) and (b) of section 612A; the Administrator's assessment of the program's cost-effectiveness; a description of any administrative actions the Administrator plans to take generally to increase the coordination of the provision of services to veterans; any recommendations for legislation relating to the provision of services to veterans that the Administrator considers appropriate; and a comparison of the Administrator's assessment, plans, and recommendations regarding the pilot program with the evaluation of, and the recommendations relating to, the readjustment counsel-

ing program which are required to be included in the report mandated by present subsection (g)(2) of section 612A.

Subparagraph (B) of paragraph (6) of new subsection (h): Would require the Administrator, not later than April 1, 1989, to submit to the Veterans' Affairs Committees a final report on the pilot program. This report would be required to include updates on the pilot program. This report would be required to include updates of all information provided in the interim report submitted pursuant to subparagraph (A) (discussed above) of this paragraph, the Administrator's final assessment of the pilot program based on its 36 months of operation, and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

Section 101—Costs: Enactment of section 101 is estimated to entail costs of $1 million in both budget authority and outlays in each of fiscal years 1986, 1987, and 1988.

Section 102

Subsection (a) of section 102 would amend present subchapter II of chapter 17 of title 38, relating to VA health-care services, to add a new section 620B, entitled "Community-based psychiatric residential treatment for chronically mentally ill veterans; pilot program", as follows:

Paragraph (1) subsection (a) of new section 620B: Would authorize the Administrator, in furnishing health-care services under chapter 17 of title 38, to conduct a 4-year (calendar years 1986–89) pilot program under which the VA would contract for the care, treatment and rehabilitation of certain chronically mentally ill veterans in halfway houses therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities. Veterans eligible to participate would be those with chronic mental illness disabilities who (under the definition of "eligible veteran" in subsection (d) (discussed below) on the new section) are, at the time of referral to such a community-based contract facility, receiving hospital, domiciliary, or nursing home care through the VA for such a disability if either that disability is service-connected or the veteran has service-connected disability or disabilities rated 50-percent or more disabling. The pilot program would be required to be planned, designed, and conducted by the VA's Chief Medical Director, with the approval of the Administrator, so as to demonstrate any medical advantages and cost-effectiveness of using the community-based contract facilities rather than VA inpatient facilities for the care, treatment, and rehabilitation of chronically mentally ill veterans and the potential of community-based contract facilities to enable such veterans to live in settings other than inpatient facilities.

Paragraph (2) subsection (a) of new section 620B: Would require the Administrator, prior to furnishing care and services to a veteran through a contract facility under the pilot program, to approve the quality and effectiveness of the program operated by the facility in which the veteran is to be furnished care and services. The Administrator would be required to prescribe in regulations the criteria for granting such approvals.

Subsection (b) of new section 620B: Would require that each VA facility furnishing care and services to veterans through contract facilities under the pilot program appoint a VA employee to provide case management services (as defined in subsection (d)(2) (discussed below) of the new section) to each veteran to whom it provides contract care and services.

Subsection (c) of new section 620B: Would authorize the VA to enter into contractual arrangements with contract facilities whereby the VA would provide the facilities with in-kind assistance—for example, the temporary, part-time services of VA employees and the use of VA supplies and equipment—and receive appropriate reimbursement therefor. Under such an arrangement, reimbursement could be by way of payment or reductions in charges otherwise payable by the VA for contractor services furnished to veterans, and the VA would be authorized to provide in-kind assistance for use solely in furnishing to veterans appropriate services under the pilot program. Funds received through reimbursement for in-kind assistance would be credited to funds allotted to the VA facility that provided the assistance.

Subsection (d) of new section 620B: Would define certain terms for the purposes of the new section, as follows: The term "eligible veteran" would mean a veteran who at the time of referral to a community-based contract facility is receiving VA hospital, domiciliary, or nursing home care for a chronic mental illness disability if either that disability is service-connected or the veteran has any service-connected disability or disabilities rated more than 50-percent disabling.

The term "case management" would include the coordination and facilitation of all services furnished to a veteran by the VA either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the VA, either directly or through a contract, or by a non-VA entity), monitoring, reassessment, and followup. (The case managers would also, to the extent feasible and appropriate, coordinate and facilitate the provision of services by non-VA entities with which the VA has not contracted.)

Paragraph (1) of subsection (e) of new section 620B: Would require the Administrator, not later than February 1, 1989, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the experience under the pilot program during the first 36 months of the program. The report would be required to include the Administrator's interim evaluation and findings regarding the quality of care provided to participating veterans through contract facilities, the effectiveness of the pilot program in enabling the participating veterans to live outside of VA inpatient facilities and to achieve independence in living and functioning in their communities, and the effect of the pilot program on the average daily census in the VA inpatient facilities participating in the program (taking into account whether the beds previously occupied by the participating veterans were subsequently occupied by other eligible veterans or remained unoccupied).

Paragraph (2) of subsection (e) of new section 620B: Would require the Administrator, not later than April 1, 1990, to submit to the

Veterans' Affairs Committees a final report on the pilot program. This report would be required to include updates of all information provided in the interim report submitted pursuant to paragraph (1) (discussed above) of this subsection of the new section, the Administrator's final evaluation, findings, and conclusions on the program based on the 48 months of operation, and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

Subsection (b) of section 102 would amend the table of sections at the beginning of chapter 17 of title 38 to reflect the addition of new section 620B proposed by subsection (a) of this section of the Committee bill.

Section 102—Costs: Enactment of section 102 is estimated to entail costs of $6 million in both budget authority and outlays in fiscal year 1986, $10 million in both budget authority and outlays in each of fiscal years 1987 and 1988, $11 million both budget authority and outlays in fiscal year 1989, and $3 million in both budget authority and outlays in fiscal year 1990. The actual cost levels will, of course, depend entirely on the extent to which the VA implements the discretionary new authority that would be provided by the proposed new section.

Section 103

Subsection (a) of Section 103 would further amend present subchapter II of chapter 17 of title 38 to add a new section 620C, entitled "Noninstitutional alternatives to institutional care; pilot program", as follows:

Paragraph (1) of subsection (a) of new section 620C: Would require—for purposes of evaluating the effectiveness, feasibility, and desirability of various actions that would obviate veterans' needs for hospital, nursing home or domciliary care—the Administrator, subject to certain funding restrictions set forth in subsection (c) (discussed below) of the new section, to conduct a 4-year (calendar years 1986–89) pilot program under which the VA would furnish to veterans who are eligible for and in need of such institutional care with medical, rehabilitative, and health-related services in noninstitutional settings. The pilot program would be carried out at 10 demonstration project sites, with at least 5 of the demonstration projects involving the use of a geriatric evaluation unit at a VA health-care facility.

Paragraph (2) of subsection (a) of new section 620C: Would require the VA, in selecting veterans for participation in the pilot program, to accord priority to veterans who have service-connected disabilities, those who are 65 or older, and those who are totally and permanently disabled.

Paragraph (1) of subsection (b) of new section 620C: Would require—for the purposes of avoiding duplication of services and to avoid fragmentation of effort under the program—that in conducting the program the VA furnish, only through contracts with appropriate non-VA providers, appropriate health-related services and assign to each participating veteran a VA employee to provide case management services. For purposes of this provision, the term "case management" would include the coordination and facilitation of all services furnished to a veteran by the VA either directly or

through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the VA, either directly or through a contract, or by a non-VA entity), monitoring, reassessment, and followup. (The case managers would also, to the extent feasible and appropriate, coordinate and facilitate the provision of services by non-VA entities with which the VA has not contracted.)

Paragraph (2) of Subsection (b) of new section 620C: Would—for the purposes of avoiding duplication of services and fragmentation of effort and evaluating the cost-effectiveness of using certain non-VA health services where no VA facility in the vicinity of a demonstration project is providing that type of services—authorize the VA, in not more than two of the demonstration projects, to contract for appropriate health services with appropriate agencies which furnish them.

Paragraph (3) of subsection (b) of new section 620C: Would authorize the VA to enter into contractural arrangements with non-VA facilities furnishing services to veterans under the pilot program whereby the VA would provide those facilities with in-kind assistance—for example, the temporary, part-time services of VA employees and the use of VA supplies and equipment—and receive appropriate reimbursement therefor. Under such an arrangement, reimbursement could be by way of payment or reductions in charges otherwise payable by the VA for services furnished to veterans, and the VA would be authorized to provide in-kind assistance for use solely in furnishing to veterans appropriate services furnished under the pilot program. Funds received through reimbursement for in-kind assistance would be credited to funds allotted to the VA facility that provided the assistance.

Paragraph (1) of subsection (c) of new section 620C: Would provide that the total costs that the VA may incur in the conduct of the pilot program may not exceed 60 percent of the cost that the VA would have incurred during the period of the pilot program if the veterans participating in the program had, instead, been furnished nursing home care in VA facilities. In any one fiscal year, the cost of carrying out the pilot program would be prohibited from exceeding 65 percent of the cost that would have been incurred in furnishing direct VA nursing home care to those veterans.

Paragraph (2) of subsection (c) of new section 620C: Would require that expenditures for services furnished to veterans under the pilot program be made only from appropriated funds that the VA would otherwise expend to provide eligible veterans with intermediate hospital care (a level of care between acute hospital care and skilled nursing home care).

Paragraph (1) of subsection (d) of new section 620C: Would require the VA to conduct a study of the pilot program in order to determine the feasibility, medical advantages, and cost-effectiveness of the pilot program services as an alternative to institutional care. The study would also be required to assess the extent to which this type of program can furnish participating veterans with more appropriate types and levels of care than they would otherwise receive, can reduce hospital, nursing home, or domiciliary facility admission rates for those veterans, can reduce the number of days that the veterans would otherwise be institutionalized, can

reduce mortality rates among those veterans, and can reduce the cost of long-term care for them.

Paragraph (2) of subsection (d) of new section 620C: Would require the Administrator, not later than February 1, 1989, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the pilot program study required by paragraph (1) (discussed above) of this subsection of the new section. The report would be required to contain the Administrator's findings based on the study of the program's first 36 months of operation; a description of the administration of the program; the Administrator's interim evaluation and findings regarding the program (including matters referred to in paragraph (1) (discussed above) of this subsection of the new section); and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

Paragraph (3) of subsection (d) of new section 620C: Would require the Administrator, not later than April 1, 1990, to submit to the Veterans' Affairs Committees a final report on the pilot program study. The report would be required to contain updates of all information required in the interim report required by paragraph (2) (discussed above) of this subsection of the new section; the Administrator's final evaluation, findings, and conclusions regarding the program based on 48 months of operation, and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report. The Administrator's final evaluations, findings, and conclusions would be required to be set forth in the context of an assessment, which the report would also be required to contain, of the needs of older eligible veterans for noninstitutional health and health-related services and of the availability of such services from non-VA sources.

Subsection (b) of section 103 would revise the table of sections at the beginning of chapter 17 to reflect the addition of new section 620C proposed in subsection (a) of this section of the Committee bill.

Section 103—Costs: Enactment of section 103 is estimated to entail no significant costs.

Section 104

Would amend chapter 17 of title 38, relating to VA hospital, nursing home, domiciliary, and medical care, to authorize limited reimbursement for chiropractic services to certain eligible veterans during the 3 calendar years 1986 through 1988.

Paragraph (1) of subsection (a) of section 104 would amend present subchapter III of chapter 17 to add a new section 630A, entitled "Chiropractic services; pilot program", as follows:

Subsection (a) of new section 630A: Would require the VA, subject to the other provisions of this section, to conduct a 3-year (calendar years 1986–88) pilot program, consisting of not less than one demonstration project in each of five geographic regions, for furnishing certain chiropractic services (specified in subsection (b) (discussed below) of the new section) to veterans eligible for medical services under chapter 17 of title 38 and for evaluating the therapeutic benefits and cost-effectiveness of furnishing chiropractic services. In developing the pilot program, the Administrator would be required

to consult with the Secretary of Defense regarding the demonstration projects carried out by the Secretary under section 632(b) of the Department of Defense Authorization Act, 1985 (Public Law 98-525), relating to demonstration projects involving the provision of chiropractic services to DOD health-care beneficiaries in order to evaluate the cost-effectiveness of chiropractic care.

Paragraph (1) of subsection (b) of new section 630A: Would provide for the reimbursement of the reasonable charges, subject to the schedule of charges that would be required to be established under subsection (c)(1) (discussed below) of the new section, for chiropractic treatment not otherwise covered by health insurance or other reimbursement or payment available to a veteran if (1) the treatment was for a service-connected neuromusculoskeletal condition of the spine, or (2) the veteran had been furnished hospital care by the VA for a neuromusculoskeletal condition of the spine within a 12-month period prior to the furnishing of chiropractic services, or (3) the veteran has a service-connected disability rated at 50-percent or more and has been furnished hospital care or medical services by the VA for a neuromusculoskeletal condition of the spine.

Paragraph (2) of subsection (a) of new section 630A: Would authorize the VA, in lieu of reimbursement to the veteran (as provided for in paragraph (1) of this subsection of the new section (discussed above)), to make payment of the reasonable charges for chiropractic services directly to the chiropractor who furnished such services.

Paragraph (1) of subsection (c) of new section 630A: Would require the Administrator, in consultation with appropriate public and nonprofit organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, to establish, consistent with the reasonable charges allowed under section 1842 of the Social Security Act (42 U.S.C. 1395u), relating to Medicare reimbursements, a schedule of reasonable charges for chiropractic services furnished under the demonstration projects.

Paragraph (2) of subsection (c) of new section 630A: Would limit the amount payable by the VA for chiropractic services provided any veteran under the demonstration projects to not more than $600 in any 12-month period.

Subsection (d) of new section 630A: Would limit total expenditures for chiropractic services reimbursed under this new section to not more than $2 million in any fiscal year and would require that expenditures for such services be made only from appropriations that would otherwise have been expended for beneficiary travel under section 111 of title 38.

Subsection (e) of new section 630A: Would require the Administrator, not later than April 1 of each of the years 1987, 1988, and 1989, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the pilot program carried out under this new section during the preceding fiscal year. Each report would be required to provide for the fiscal year involved the number of requests made by eligible veterans for reimbursement or payment for chiropractic services under this new section and the number of veterans who made the requests; the number of the reimbursements of payments that were

made and the number of veterans to or for whom there were made; and the total amount of the expenditures for these reimbursements and payments.

Paragraph (2) subsection (a) of new section 104 would amend the table of sections at the beginning of chapter 17 of title 38 to reflect the addition of new section 630A proposed in paragraph (1) of this subsection of the Committee bill.

Subsection (b) of new section 104 would amend present section 601, relating to definitions, to add a new paragraph (9), as follows:

New paragraph (9): Would define the term "chiropractic services" as the manual manipulation of the spine to correct a subluxation of the spine; the definition would exclude physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded. Also by virtue of this definition, the VA would pay, under new section 630A of title 38 (as proposed to be added by subsection (a)(1) (discussed above) of this section of the Committee bill), only for services that are provided by chiropractors who are licensed and meet the minimum national standards for chiropractors promulgated under section 1861(r)(5) of the Social Security Act (42 U.S.C. 139x(r)(5)).

Section 104—Costs: Enactment of section 104 is estimated to entail costs of $2 million in both budget authority and outlays in each of fiscal year years 1986, 1987, and 1988, and $1 million in both budget authority and outlays in fiscal year 1989.

TITLE II—EXTENSIONS OF AUTHORITIES AND ELIGIBILITIES

Section 201

Subsection (a) of section 201 would amend present section 101(29) of title 38, defining for title 38 purposes the term "Vietnam era" as the period beginning on August 5, 1964, and ending on May 7, 1975, to provide that the Vietnam era also includes the period beginning on February 21, 1961 (the date established in Public Law 89-257 for acceptance of foreign awards for service in Vietnam), and ending on August 4, 1964 (the day before the starting date of the era in current law) in the case of those who served in the Republic of Vietnam during that period. The effect of this amendment would be to provide those who served in Vietnam during the 3 years and 5½ months prior to the current beginning date of the Vietnam era with general eligibility (subject to any applicable length-of-service requirements) under the following title 38 provisions: For non-service-connected pension benefits under chapter 15 (for those who also meet the disability (or age) requirement and income and net worth limitations); readjustment counseling under section 612A; certain burial benefits under section 902 (for those who are destitute and whose bodies are not claimed); home-loan guaranty benefits under chapter 37 (in the cases of those who served more than 89 but less than 181 days); and certain employment benefits under chapters 41 and 42.

Subsection (b) of section 201 would provide for the amendment made by subsection (a) of this section of the Committee bill to take effect on October 1, 1985.

Section 201—Costs: Enactment of section 201 is estimated to entail no significant costs.

Section 202

Would amend paragraph (3) of present section 610(e) of title 38, relating to the period during which veterans exposed to dioxin or other toxic substances in Vietnam during the Vietnam era or to ionizing radiation from the detonation of a nuclear device are eligible for certain VA health-care services for disabilities which cannot be disassociated from that exposure, to extend the period of eligibility by 2 years and 7 months—from the end of the 1-year period beginning on the date that the Administrator submits a first report on a mandated epidemiological study (which is due to be submitted by February 14, 1986) until the end of fiscal year 1989.

Section 202—Costs: Enactment of section 202 is estimated to entail no costs in fiscal year 1986 and costs of $20 million in both budget authority and outlays in fiscal year 1987, and $40 million in both budget authority and outlays in fiscal year 1988, and $40 million in both budget authority and outlays in fiscal year 1989.

Section 203

Subsection (a) of section 203 would further amend subchapter II of chapter 17 of title 38 to add a new section 612B, entitled "Eligibility for counseling for former prisoners of war", as follows:

New section 612B: Would authorize the Administrator to establish a program under which the VA, upon the request of a veteran who is a former prisoner of war, would be authorized to furnish, within the limits of VA facilities, counseling to the veteran in order to assist the veteran in overcoming the psychological effects of detention or internment as a prisoner of war.

Subsection (b) of section 203 would provide for the amendment made by subsection (a) of this section of the Committee bill to take effect on October 1, 1985.

Section 203—Costs: Enactment of section 203 is estimated to entail no significant costs.

Section 204

Clause (1) of subsection (a) of section 204 would amend subsection (a)(1) of present section 620A of title 38, relating to a 5-year pilot program for the furnishing of alcohol and drug treatment and rehabilitation through contracts with non-VA halfway houses and other community-based programs, to delete a reference to the program as a "pilot" program. Under this amendment and similar amendments proposed to be made by clauses (2) and (4) (discussed below) of this subsection and by subsection (b) (disscussed below) of this section of the Committee bill, the program would no longer be regarded as a pilot program.

Clause (2) of subsection (a) of section 204 would amend subsection (e) of present section 620A to extend by 3 years, through September 30, 1988, the duration of the contract alcohol and drug treatment program authorized by section 620A(a) and to delete a reference to the program as a "pilot" program.

Paragraph (3) of subsection (a) of section 204 would amend subsection (f) of present section 620A to revise the current requirement for a report on the pilot phase of the program to establish, instead, new monitoring and reporting requirements, as follows:

Clause (A) of new paragraph (1) of subsection (f) of section 620A: Would require the Administrator to monitor the performance of the contract alcohol and drug treatment programs providing services under section 620A(a) to determine the medical advantages and cost effectiveness that result from providing services through contract facilities.

Clause (B) of new pargraph (1) of subsection (f) of section 620A: Would require the Administrator to monitor the performance of the contract alcohol and drug treatment facilities to determine the medical advantages and cost-effectiveness of the care and services furnished by the contract facilities and to determine, with respect to those facilities generally, the level of success under the overall program, taking into account (1) the rate of successful rehabilitation, (2) the rate of readmission of participants to contract and VA facilities for drug or alcohol disabilities, (3) whether veterans participating in the contract programs were able to avoid hospitalization for drug or alcohol disabilities, (4) the average duration of the care and services veterans received under the program, (5) the ability of the program to assist veteran participants with the transition back into their communities, and (6) any other factors the Administrator considers appropriate. The Administrator would also be required to make determinations relating to the total cost for care and services furnished by each contract facility, the average cost per veteran under the program, and the appropriateness of those costs, taking into account the average charges from other community facilities which furnish care and services similar to those furnished under the program and the historical costs for care and services furnished under the contract program during the time when the program was a pilot program (prior to fiscal year 1986).

New paragraph (2) of subsection (f) of section 620A: Would require the Administrator, not later than February 1, 1988, to submit to the House and Senate Committees on Veterans' Affairs a report on the experience under the contract program during fiscal years 1984 through 1987, including a description of the care and services provided under the program, the matters specified in paragraph (1) of this new subsection (f) (duscussed above), and the Administrator's findings, assessment, and recommendations regarding the contract program.

Clause (4) of subsection (a) of section 204 would amend the section heading of present section 620A to delete, consistent with the amendments proposed to be made by clauses (1) and (2) (discussed above) of subsection (a) of this section of the Committee bill, the words "pilot program".

Subsection (b) of section 204 would amend the item relating to section 620A at the beginning of chapter 17 of title 38, to delete, consistent with the amendment proposed to be made by clauses (1), (2), and (4) of subsection (a) of this section of the Committee bill, the words "pilot program".

Section 204—Costs: Enactment of section 204 is estimated to entail costs of $6 million in both budget authority and outlays in each of fiscal years 1986, 1987, and 1988.

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TITLE III—HEALTH-CARE MANAGEMENT

Section 301

Would amend present section 210(b) of title 38, relating to the general authority of the Administrator, to add a new paragraph (3), as follows:

Division (i) of subparagraph (A) of new paragraph (3): Would preclude the Administrator, in any fiscal year, from carrying out a grade reduction (as described in division (ii) (discussed below) of new subparagraph (A)) unless the Administrator first submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report containing a detailed plan for the proposed reduction and a detailed justification for the reduction, including the Administrator's determination, supported by appropriate data, that, in the personnel area proposed for the reduction, the VA has a disproportionate number of employees at the salary grade or grades involved in comparison to the number of employees at the same salary level or levels who perform comparable functions in other departments and agencies of the Federal Government and in non-Federal entities. Any report of a proposed reduction submitted pursuant to this division would have to be submitted at least 90 days prior to the effective date of the reduction, and that 90-day period could not include any day on which either the Senate or the House was not in session.

Division (ii) of subparagraph (A) of new paragraph (3): Would define a VA grade reduction, for purposes of division (i) (discussed above) of subparagraph (A) of the new paragraph, as a systematic reduction, for the purpose of reducing the average salary cost for certain VA employees (described in division (iii) (discussed below) of new subparagraph (A)), in the number of those VA employees at any particular salary grade level.

Division (iii) of subparagraph (A) of new paragraph (3): Would specify that the VA employees referred to in division (ii) of subparagraph (A) (discussed above) of the new paragraph—*i.e.*, the employees as to which no grade reduction would be permitted to take place except in accordance with division (i) (discussed above) of subparagraph (A) of the new paragraph—are health-care personnel whom the Administrator determines are providing either direct patient-care services or services incident to direct patient-care services and individuals who meet the definition of "professional employee" as that term is defined in section 7103(a)(15) of title 5, United States Code, and who are employed by the VA in the capacity of engineers or attorneys. The section 7103(a)(15) definition is as follows:

> (15) "professional employee" means—
>
> (A) an employee engaged in the performance of work—
>
> (i) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital (as distinguished from knowledge acquired by a general academic education, or from an apprenticeship, or from training in the performance of routine mental, manual, mechanical, or physical activities);

(ii) requiring the consistent exercise of discretion and judgment in its performance;

(iii) which is predominantly intellectual and varied in character (as distinguished from routine mental, manual, mechanical, or physical work); and

(iv) which is of such character that the output produced or the result accomplished by such work cannot be standardized in relation to a given period of time; or

(B) an employee who has completed the courses of specialized intellectual instruction and study described in subparagraph (A)(i) of this paragraph and is performing related work under appropriate direction or guidance to qualify the employee as a professional employee described in subparagraph (A) of this paragraph . . . .

Subparagraph (B) of new paragraph (3): Would require—not later than 45 days after the Administrator submits a report pursuant to subparagraph (A) of the new paragraph (discussed above) relating to a proposed grade reduction (and thus containing a detailed plan and justification for the reduction, including a determination as to the relationship between VA and non-VA salary levels)—that the Comptroller General of the United States submit to the Committees on Veterans' Affairs a report on the Administrator's compliance with subparagraph (A) (discussed above) of the new paragraph and that there be set forth in the report the Comptroller General's opinion as to the accuracy of the Administrator's determination that the VA employees affected are relatively overgraded in comparison to non-VA employees at the same grade level or levels and as to the accuracy of the data supporting that determination.

Subparagraph (C) of new paragraph (3): Would preclude the Administrator from carrying out in any fiscal year a systematic grade reduction for the purpose of reducing the average salary cost of VA employees other than those described in division (iii) of subparagraph (A) (discussed above) of the new paragraph (3) (that is, other than certain health-care personnel, engineers, and attorneys) if such a grade reduction would result in a reduction in the number of those VA employees at any grade level or levels at a rate greater than the rate of the reductions being made in a systematic way in the numbers of employees at the same grade level or levels in all other Federal agencies and departments combined.

Section 301—Costs: Enactment of section 301 is estimated to entail no significant costs.

Section 302

Would amend present section 3305, relating to limitations on the disclosure of certain VA medical quality-assurance records, to specify certain limits on the coverage of that section.

Clause (1) of section 302 would amend subsection (a) of section 3305 to add a cross-reference to reports submitted to the Committees on Veterans' Affairs pursuant to new section 4152 of title 38 (as proposed to be added by section 304 (discussed below) of the Committee bill) so as to specify that those reports (bi-annual reports on the VA's experience under a proposed medical quality-assurance program which would include, among other things, data on

mortality and morbidity rates for VA surgical programs and procedures) would not be confidential under section 3305 and thus, unless other grounds existed for their non-disclosure, would be available for disclosure to the public.

Clause (2) of section 302 would amend subsection (b) of section 3305 so as to add a new paragraph (6), as follows:

New paragraph (6): Would specify that nothing in section 3305 authorizes or requires the VA to withhold the disclosure of statistical information on VA health-care programs, including information on aggregate morbidity and mortality rates at individual VA health-care facilities, so long as that information does not identify, either explicitly or implicitly, individual VA patients or employees or individuals who participated in medical quality-assurance activities. Thus, unless other grounds existed for non-disclosure, statistical information on VA health-care programs which would not identify such individuals would be available for disclosure to the public.

Section 302—Costs: Enactment of section 302 is estimated to entail no significant costs.

Section 303

Would amend present section 4110 of title 38, relating to disciplinary actions against physicians and certain other health-care personnel employed by the VA, to add new subsections (f) and (g), as follows:

New subsection (f): Would provide that the provisions of section 4110, relating to disciplinary actions involving individuals employed in the VA's Department of Medicine and Surgery under the authority of title 38, United States Code, that is, physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded function dental auxiliaries, are applicable in any case in which the VA proposes to reduce or revoke the clinical privileges of any such individual by reason on inaptitude, inefficiency or misconduct. In addition, a disciplinary board would be permitted to recommend, and the Administrator would be permitted to impose, a revocation or reduction of the clinical privileges in a case involving such an individual VA health-care employee only if, prior to the hearing provided for in subsection (a) of section 4110, the individual was provided with notice of the proposal to reduce or revoke his or her privileges and only on the basis of a deficiency in the individual's clinical practice.

New subsection (g): Would specify that nothing in section 4110 (either under present law or as it is proposed to be amended by this section of the Committee bill) limits the Administrator's authority to protect the health and safety of veterans by temporarily reassigning a VA title 38 employee for the purpose of either suspending the employee's exercise of clinical privileges or otherwise restricting his or her clinical activities pending the outcome of a proceeding under section 4110.

Section 303—Costs: Enactment of section 303 is estimated to entail no significant costs.

Section 304

Would amend chapter 73 of title 38, relating to the VA's Department of Medicine and Surgery (DM&S), in order to improve VA

programs for assuring the quality of DM&S health-care services and would require the VA to provide a series of reports on its monitoring of the credentials of VA health-care professionals.

Subsection (a) of section 304 would amend chapter 73 to add a new subchapter V, entitled "Quality Assurance", and consisting of two new sections, section 4151, entitled "Responsibilities for quality assurance", and section 4152, entitled "Reports", as follows:

New section 4151: Would set forth the responsibilities for medical quality assurance within the VA as follows:

Clause (1) of subsection (a) of new section 4151: Would require the administrator to establish and conduct a comprehensive quality-assurance program in order to monitor and evaluate the quality of health care furnished by DM&S.

Clause (2) of subsection (a) of new section 4151: Would require the administrator to delineate the responsibilities of DM&S with respect to the VA's quality-assurance program.

Clause (3) of subsection (a) of new section 4151: Would require the Administrator to allocate sufficient resources and sufficient personnel with the necessary skills and qualifications to DM&S to enable it to carry out its delineated quality-assurance responsibilities.

Subsection (b) of new section 4151: Would require the VA's Inspector General (IG) to allocate sufficient resources and sufficient personnel with the necessary skills and qualifications to enable the IG to monitor the VA's quality-assurance program as carried out by DM&S.

Subsection (c) of new section 4151: Would require the Administrator, as part of the VA's quality-assurance program, to require the Chief Medical Director (CMD) (1) in consultation with the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Armed Forces and other appropriate professional bodies, to establish and maintain a compilation of prevailing national mortality and morbidity standards for each type of surgical procedure conducted by DM&S; (2) to collect mortality and morbidity data for each surgical procedure conducted by DM&S and to compile the data (for inclusion in the report required by new section 4152 (proposed to be added by this subsection (discussed below) of the Committee bill)) for each cardiac surgery, heart transplant, and renal transplant program and in the aggregate for each other surgical procedure; (3) to compare the mortality and morbidity data compiled pursuant to clause (2) of this subsection of the new section (discussed above) with the prevailing national mortality and morbidity standards compiled pursuant to clause (1) (discussed above) of this subsection of the new section; (4) to make an analysis of the relationship between such VA data and the characteristics of the patient population involved, the level of risk for the procedure involved (taking into consideration various specified circumstances) and any other factors the CMD considers appropriate; (5) to evaluate the VA data in light of the characteristics of the patient population involved, the level of risk, and other factors considered appropriate in order to determine whether there are any significant deviations from the standards that would indicate deficiencies in the VA's quality of care; (6) to explain any deviations in VA quality of care which the CMD identifies; and (7) to make recommendations based on the data compiled and the comparisons, analyses,

evaluations, and explanation made pursuant to clause (3) (discussed above) of this subsection of the new section.

Subsection (a) of new section 4152: Would require the CMD to submit three reports to the Administrator, the first by January 1, 1987, and the second and third 2 and 4 years later, respectively, on the experience through the end of the prior fiscal year under the quality-assurance program carried out pursuant to subsection (a) of new section 4151 (as proposed to be added by this subsection (discussed above) of the Committee bill). Within 60 days after receiving each report, the Administrator would be required to submit a copy of the report to the Committees on Veterans' Affairs of the Senate and House of Representatives, together with any comments regarding the report that the Administrator considers appropriate.

Subsection (b) of new section 4152: Would specify that a report submitted pursuant to subsection (a) of the new section would not be considered a record or document for purposes of section 3305(a), relating to limitations on the disclosure of certain VA medical quality-assurance records, as that section is proposed to be amended by section 302 of the Committee bill. Thus, unless other grounds exist for non-disclosure, the reports would be available for disclosure to the public.

Subsection (b) of section 304 would amend the table of sections at the beginning of chapter 73 of title 38 to reflect the addition of new subchapter V proposed by subsection (a) of this section of the Committee bill.

Paragraph (1) of subsection (c) of section 304 would require the Administrator, not later than 90 days after the date of the enactment of this Act, to submit to the Senate and House of Representatives Committees on Veterans' Affairs a report describing in detail the VA's current efforts and future plans for monitoring the credentials of VA health-care professionals.

Paragraph (2) of subsection (c) of section 304 would specify that the report required by paragraph (1) of this subsection of the Committee bill must include a description of VA policies, procedures, and formal arrangements regarding the exchange of relevant information with appropriate State medical and other health-professional licensing bodies, the Federation of State Medical Boards, the American Medical Association, and any other public or private entities the Administrator considers appropriate that are involved with issuing or monitoring health-care professional licenses. The exchanges of information that would be required to be described are those accomplished for the purposes of (1) determining the current and past licensure and clinical privilege status for health-care professionals who are seeking VA employment or who are currently employed by the VA; and (2) providing information to appropriate non-VA entities about health-care professionals whose VA employment is terminated in certain circumstances. Those circumstances would include a termination after the completion of a disciplinary action in which the question regarding the individual's clinical competence was resolved against the individual; a voluntary termination after the individual's clinical privileges were restricted or revoked; or a voluntary termination after serious concerns about the individual's clinical competence were raised but not resolved.

Paragraph (3) of subsection (c) of section 304 would require the Administrator, in the report required to be submitted pursuant to paragraph (1) (discussed above), of this subsection of the Committee bill to provide a timetable for the implementation of any policies, procedures, or formal arrangements described in paragraph (2) (discussed above) of this subsection of the Committee bill which have not been implemented by the time of the report. Until full implementation was achieved, the Administrator would be required to submit to the Veterans' Affairs Committees implementation progress reports every 3 months. Upon achieving implementation, the Administrator would be required to submit a final report.

Section 304—Costs: Enactment of section 304 is estimated to entail no significant costs.

TITLE IV—MEDICAL FACILITY CONSTRUCTION AND PLANNING

Part A—Permanent Annual Authorization Process

Section 401

Would amend present section 5004 of title 38, relating to Congressional approval of certain projects to construct, alter, or acquire VA medical facilities, to improve the process for granting such approval.

Subclause (A) of clause (1) of subsection (a) of section 401 would amend clause (1) of present section 5004(a), relating to Congressional approval of VA medical facility construction, alteration, or acquisition (other than by way of exchange or lease) projects entailing total costs of $2 million or more, to provide that appropriations may not be made for major projects (those involving the expenditure of $2 million or more) to construct, alter, or acquire VA medical facilities except as authorized by a law setting forth the amount that may be appropriated and expended for such projects that is based on legislation reported from the Committees on Veterans' Affairs of the Senate and the House of Representatives. This authorization-of-appropriations-legislation approach to the approval of VA construction projects would replace the approach provided for in current law under which no appropriations may be made for such projects unless the Committees on Veterans' Affairs have adopted resolutions approving such projects and setting forth the estimated costs.

Subclause (B) of clause (1) of subsection (a) of section 401 would further amend section 5004(a) to redesignate existing clause (2) as clause (4) and add new clauses (2) and (3), as follows:

New clause (2) of subsection (a) of section 5004: Would prohibit the expenditure of any funds for a project involving the construction, remodeling, extension, or acquisition (other than funds necessary to develop project requirements) of a medical facility if the project involves the expenditure of more than $20 million unless the project is authorized by a law based on legislation reported from the Committees on Veterans' Affairs of the Senate and the House of Representatives. Under current law (by virtue of the definition of the terms "contruct" and "alter" in present section 5001(1), which includes only work following the development of preliminary plans), such projects are not subject to Congressional ap-

proval in any fashion until advanced planning, through preliminary plans, is completed.

New clause (3) of subsection (a) of section 5004: Would prohibit the construction or acquisition of any new or replacement medical facility with in excess of 700 hospital beds and the undertaking of any project involving the expenditure of more than $20 million for remodeling or expanding an existing medical facility if, upon completion of the project, the number of hospital beds would exceed 700. Under current law, present section 5001(1), the definition of the term "alter" includes four terms—"repair", "remodel", "improve", and "extend". This provision of the Committee bill (which by its terms applies only to projects to "construct", "remodel", or "extend" a facility) would not apply to a project that is limited to work to "repair" or "improve" an existing VA facility and thus is not intended to apply to projects—such as those to make seismic corrections or fire and safety improvements and to correct patient-privacy deficiencies—that do not involve enlarging the capacity of or extensively renovating the facility.

Clause (2) of subsection (a) of section 401 would amend present subsection (c) of section 5004, relating to the extent to which the contract price for a project may, by reason of inflationary causes, exceed the estimated cost set forth in the Veterans' Affairs Committees' resolutions of approval, to make changes clarifying the wording of section 5004(c) and to conform it to the changes proposed to be made by subclause (A) of clause (1) (discussed above) of this subsection of the Committee bill. Thus, section 5004(c) would apply to cost amounts specified (1) in resolutions adopted with respect to construction, alteration, and acquisition project prior to the amendment taking effect, (2) in resolutions adopted with respect to leases, and (3) in laws (enacted pursuant to section 5004(a)(1) as proposed to be amended by section 401(a)(1)(A) (discussed above) of the Committee bill) authorizing appropriations and expenditures for construction, alteration, and acquisition projects.

Clause (3) of subsection (a) of section 401 would amend present subsection (d) of section 5004, relating to the rescission of Veterans' Affairs Committees' approvals for certain projects for which appropriations have not been made, to make a conforming amendment to reflect the changes proposed to be made by subclause (A) of clause (1) (discussed above) of this subsection of the Committee bill, deleting from the Committee-approval process the construction and alteration of facilities and the acquisitions of facilities other than leases. Thus, section 5004(d) would remain applicable only to leases.

Subsection (b) of section 401 would establish effective dates for this section of the Committee bill.

Paragraph (1) of subsection (b) of section 401 would provide that, except as otherwise provided in paragraph (2) of this subsection, the amendments made by this section of the Committee bill shall take effect on October 1, 1986.

Paragraph (2) of subsection (b) of section 401 would provide that the amendments proposed to be made by clause (1) of subsection (a) of this section of the Committee bill (relating to changes in the Congressional approval/authorization process) shall take effect with respect to appropriations for fiscal year 1987 but shall not apply with respect to projects approved by the Committees on Vet-

erans' Affairs (through Committee resolutions) prior to September 30, 1985.

Section 401—Costs. Enactment of section 401 is estimated to entail no significant costs.

Section 402

Would amend present subchapter I of chapter 81 of title 38, relating to the construction acquisition, and operation of VA medical facilities, to require the development of a new methodology for the sizing of hospital facilities.

Subsection (a) of new section 5004A: Would require—for the purpose of ensuring that decisions regarding the need for and size of proposed new or replacement VA hospital facilities are based on appropriate statutory eligibility and priorities for VA health care—the Administrator and the Comptroller General of the United States jointly (after consultation with the Assistant Secretary of Defense for Health Affairs, veterans' service organizations, and representatives of the private hospital industry) to develop and submit to the appropriate committees of the Congress a methodology for determining the appropriate types of hospital beds and numbers of each type of hospital bed to be provided for in the proposed construction of new or replacement VA hospital facilities.

Subsection (b) of section 5004A: Would require that the hospital-sizing methodology required by subsection (a) (discussed above) of the new section taken into account (1) the projected need for health care of veterans to be served by the facility who either have service-connected disabilities or meet the income criteria for VA pension under chapter 15 of title 38, under which need-based pension is provided to non-service-connected totally and permanently disabled or elderly wartime veterans, and (2) recent or planned changes in treatment modalities for the furnishing of inpatient and outpatient care which could affect demand for inpatient bed capacity.

Paragraph (1) of subsection (c) of new section 5004A: Would require the Administrator and the Comptroller General, not later than October 1, 1986, to submit to the appropriate committees of the Congress a report on the new methodology that they are to develop under subsection (a) (discussed above) of the new section.

Paragraph (2) of subsection (c) of new section 5004A: Would require the Administrator and the Comptroller General, not later than Ocobter 1, 1987, to submit to the appropriate committees of the Congress report on the implementation of the new methodology developed under subsection (a) (discussed above) of new section 5004A.

Paragraph (3) of subsection (c) of new section 5004A: Would require the Comptroller General to submit to the appropriate committees of the Congress such additional reports as the Comptroller General considers appropriate regarding the implementation of the new methodology developed under subsection (a) (discussed above) of the new section or regarding the need to revise that methodology.

Subsection (d) of new section 5004A: Would prohibit the expenditure of any funds after April 1, 1987, for purposes of developing preliminary plans for any VA hospital facility unless the types and

numbers of beds to be provided in the facility are based on the new methodology required to be developed under subsection (a) (discussed above) of the new section.

Subsection (b) of section 402 would amend the table of sections at the beginning of chapter 81 to reflect the addition of new section 5004A proposed by subsection (a) of this section of the Committee bill.

Section 402—Costs: Enactment of section 402 is estimated to entail no significant costs.

Section 411

Part B—Fiscal Year 1986 Construction Authorizations

Subsection (a) of section 411 would authorize, for purposes of the medical facility construction projects identified in subsection (b) of this section of the Committee bill and for other construction projects and for other purposes, the appropriation to the VA for fiscal year 1986 of $417.2 million to an account from which major VA medical facility construction projects (those involving the expenditure of $2 million or more) are funded and $194.4 million to an account from which minor VA medical-facility construction projects (those involving the expenditure of less than $2 million) are funded. Assuming that the fiscal year 1986 appropriations process follows the legislative format of recent years, the authorizations would be for appropriations to the VA appropriations accounts entitled "Construction, Major Projects" and "Construction, Minor Projects", respectively.

Subsection (b) of section 411 would establish maximum amounts that are authorized to be appropriated and expended for certain major medical-facility replacement/modernization construction projects subject to the amount authorized to be appropriated in subsection (a) (discussed above) of this section of the Committee bill for major construction projects.

Paragraph (1) of subsection (b) of section 411 would, subject to the amount so authorized and except as provided in paragraph (2) (discussed below) of this subsection of the Committee bill establish maximum amounts that could be appropriated and expended for projects in Houston, Texas; Mountain Home, Tennessee; and Philadelphia, Pennsylvania. The maximum amounts that would be established by this paragraph of the bill represent the unfunded balance (*i.e.,* the amount for which appropriations have not yet been made) of the total costs of these projects as estimated by the VA.

Paragraph (2) of subsection (b) of section 411 would, subject to the provisions of paragraph (3) (discussed below) of this subsection of the Committee bill, and the amount of the major construction authorization in subsection (a) (discussed above) of this section of the Committee bill, further limit the amounts that may be appropriated and expended for projects in Houston, Mountain Home, and Philadelphia. The maximum amounts that would be established by this paragraph represent the unfunded balance of the total costs of these projects as approved by the Committee in its resolution of May 24, 1984.

Paragraph (3) of subsection (b) of section 411 would specify that the maximum amount that would be established for a project by

paragraph (2) of this subsection of the Committee bill would apply unless the Administrator certifies to the appropriate committees of the Congress (not later than 60 days after the date of enactment of the Committee bill) that a contract for construction of that project at a bedsize level consistent with that maximum amount could not feasibly be awarded within 180 days after (1) the date on which such a contract was scheduled to have been made as of June 1, 1985, in the case of the projects in Houston, and Mountain Home, or (2) September 1, 1986, in the case of the project in Philadephia. Any such certification submitted by the Administrator would be required to be accompanied by submissions of three architectural/engineering firms (one of which would be the firm retained by the VA to complete the plans for the project, one of which would be selected by the American Institute of Architects (at the Administrator's request), and one of which would be selected by the Comptroller General of the United States), at least two of which support the Administrator's certification.

Subsection (c) of section 411 would authorize the expenditure during fiscal year 1986 of funds in the VA's major construction working reserve account for the redesign of three major replacement/modernization projects (in Augusta, Georgia; Baltimore, Maryland; and New York) if the total expenditures for the projects as redesigned did not exceed the amounts specified in this subsection of the Committee bill for them. The maximum amounts (which are lower in each case than the amounts that the VA estimates) that would be established by this subsection represent the unfunded balance of the total costs of these projects as approved by the Committee in its resolution of May 24, 1984.

Section 411—Costs: Enactment of section 411 is estimated to entail costs of $612 million in budget authority and $58 million in outlays in fiscal year 1986, no budget authority and $133 million in outlays in fiscal year 1987, no budget authority and $164 million in outlays in fiscal year 1988, no budget authority and $113 million in outlays in fiscal year 1989, and no budget authority and $57 million in outlays in fiscal year 1990.

Part C—Alternatives To and For Construction

Section 421

Would amend provisions of present subchapter I of chapter 81 of title 38, relating to the acquisition, construction, and operation of VA medical facilities.

Subsection (a) of section 421 would amend present section 5002 of title 38, relating to the construction and acquisition of medical facilities, to add a new subsection (d), as follows:

Paragraph (1) of new subsection (d) of section 5002: Would require the Administrator, in connection with the assessment of the health-care needs of veterans in a particular area for the purpose of planning how best to meet those needs, to develop criteria for determining whether to proceed with planning for the construction or acquisition of a new or replacement medical facility and, if it is determined to proceed, for choosing among the alternatives of construction of a new or replacement facility and of leasing or purchasing an existing medical facility that meets VA needs and speci-

fications and certain other requirements as specified in paragraph (3) (discussed below) of this new subsection.

Paragraph (2) of new subsection (d) of section 5002: Would prohibit the Administrator, after January 1, 1986, from proceeding to develop preliminary plans for construction of a new or replacement medical facility except in accordance with the criteria required to be developed by paragraph (1) (discussed above) of this new subsection and unless the Administrator has considered the option of leasing or purchasing an existing medical facility that meets the requirements specified in paragraph (3) (discussed below) of this new subsection.

Paragraph (3) of new subsection (d) of section 5002: Would set forth, in clauses (A) through (D), the criteria which must be met in order for an existing medical facility to be required to be considered for lease or purchase as an alternative to construction, as follows:

Clause (A) of paragraph (3) of new subsection (d) section 5002: Would require that the existing facility be available (or be available in timely fashion in the foreseeable future) for purchase or lease.

Clause (B) of paragraph (3) of new subsection (d) of section 5002: Would require that the existing facility meet, or be adaptable to meet, both the current and the projected needs and specifications of the VA for furnishing health care to veterans residing within a 100-mile radius of where a new or replacement facility would be located.

Clause (C) of paragraph (3) of new subsection (d) of section 5002: Would require that it be possible to acquire the facility at an estimated cost (including the cost of any required adaptations) that does not exceed the cost of construction of a comparable new or replacement facility.

Clause (D) of paragraph (3) of new subsection (d) of section 5002: Would require that the estimated operating costs for the existing facility (after any necessary adaptation) not exceed the estimated operating costs for a comparable new or replacement facility.

Subsection (b) of section 421 would amend clause (1) of present section 5004(b), relating to the submission of prospectuses for major medical facility construction projects proposed by the VA, to require that, in the case of a project for the construction of a new or replacement medical facility, the prospectus include a description of the consideration that was given to the purchase or lease of an existing facility pursuant to the criteria established under paragraph (3) of section 5002(d) (as proposed to be added by subsection (a) of this section of the Committee bill).

Section 421—Costs: Enactment of section 421 is estimated to entail no significant costs.

Section 422

Subsection (a) of section 422 would require the Administrator to enter into a contract with an appropriate entity for the construction and operation of a nursing home care unit (solely for veterans eligible for nursing home care under chapter 17 of title 38) that meets the VA's current and projected needs and specifications (including those relating to location and site selection). Clause (1)

through (6) of this section of the bill would set forth certain provisions that would be required to be contained in the contract.

Clause (1) of subsection (a) of section 422 would require that the contract provide for the contractor to operate the nursing home for a 5-year period following the completion of the construction and that the contractor staff, equip, and operate the nursing home so as to provide the same types, levels, and quality of care that the VA would otherwise be providing directly.

Clause (2) of subsection (a) of section 422 would require that the contract permit the Administrator to renew the contract for an additional term not to exceed 5 years.

Clause (3) of subsection (a) of section 422 would require the VA to refer a sufficient number of veteran-patients to the nursing home to ensure a specified occupancy rate for the term of the contract—approximately equal to the average occupancy rate in VA nursing homes nationwide, except that the Administrator could require a higher occupancy rate if the Administrator determines that a higher rate would be in the best interests of the United States.

Clause (4) of subsection (a) of section 422 would require that the contract provide that the per-diem rate paid to the contractor not exceed the average daily costs to the VA of operating its own nursing home care units, i.e., approximately $113 per day for fiscal year 1985.

Clause (5) of subsection (a) of section 422 would require that the contract provide that all rights, title, and interest in the nursing home constructed under this section vest in the United States.

Clause (6) of subsection (a) of section 422 would require the Administrator to include in the contract such other provisions as the Administrator determines to be in the best interests of the United States.

Subsection (b) of section 422 would provide for subsection (a) of this section of the Committee bill to take effect on October 1, 1985.

Section 422—Costs: Enactment of section 422 is estimated to entail no significant costs.

Section 423

Would require the Administrator, in connection with the submission of the budget for VA for fiscal year 1987, to provide a feasibility plan for the purchase of a medical facility that is located in an urban area, is suitable for furnishing both hospital and nursing home services, and meets the current and projected needs and specifications of the VA (including identification for the catchment area where the services of the new facility are needed). In addition, the President would be required to include in the VA's fiscal year 1987 budget, as warranted by the feasibility plan, a request for an appropriate amount to enable the VA to purchase a facility which meets the VA's needs and specifications.

Section 423—Costs: Enactment of section 423 is estimated to entail no significant costs.

Section 424

Would require the Administrator, within 180 days after the date of the enactment of the Committee bill, to enter into a contract for the development of an approach using modular components in the

design and construction of hospital facilities so that the applicability and cost-effectiveness of such an approach in VA hospital construction can be evaluated.

Section 424—Costs: Enactment of section 424 is estimated to entail no significant costs.

TITLE V—MISCELLANEOUS PROVISIONS

Section 501

Would make a technical, conforming amendment to present section 612A(g)(1)(B) of title 38, relating to the Administrator's responsibility during the 12-month period ending September 30, 1988, for planning for the continued availability of readjustment counseling, to delete a reference to a date by which veterans would have to request such counseling in order for the Administrator to be required to take them into account in the planning required by section 612A(g)(1). This, the planning requirement in section 612A(g)(1) would be conformed to the ongoing counseling eligibility provided for in section 612A(a).

Section 501—Costs: Enactment of section 501 is estimated to entail no costs.

Section 502

Subsection (a) of section 502 would amend present section 618 of title 38, relating to VA patients' work in certain VA therapeutic or rehabilitative work activities, to provide that remuneration provided to a veteran or other participant in a therapeutic or rehabilitative activity carried out pursuant to present section 618, shall not be counted as income for the purpose of payments of VA pension programs, including both the current, so-called "improved" pension program, under chapter 15 of title 38, and the closed programs under which payments are made only to those who were "grandfathered" under a prior program, *i.e.,* were permitted (by section 9(b) of the Veterans' Pension Act of 1959 or section 306(a)(2) of the Veterans' and Survivors' Pension Improvement Act of 1978) to continue receiving the amount of pension they were receiving at the time that a new pension program went into effect. With certain specified exceptions, all income received by a VA pensioner under the current "improved" program reduces that individual's pension dollar for dollar. In the case of "grandfathered" participants in the closed programs, their eligibility for continued payment depends on their total annual non-pension income remaining below specified amounts.

Subsection (b) of section 502 would provide for the amendment made by subsection (a) of this section of the Committee bill to take effect on October 1, 1985.

Section 502—Costs: The enactment of section 502 is estimated to entail costs of $1 million in both budget authority and outlays in each of fiscal years 1986 through 1990.

Section 503

Would require the Secretaries of Defense and of Health and Human Services and the Administrator to submit to the Congress a joint report on the question of U.S. Government responsibility for

providing benefits and services to individuals who, during service in Vietnam with voluntary organizations that provided significant assistance to the U.S. Armed Forces, incurred disabilities that may be related to their service in Vietnam.

Paragraph (1) of subsection (a) of section 503 would state that the purpose of this section of the Committee bill is to provide a basis for the executive branch and the Congress to evaluate the question of U.S. Government responsibility, and alternative approaches, for providing individuals who, for a period of at least 30 days during the Vietnam era, were employed in the Republic of Vietnam by voluntary organizations that provided significant assistance to the U.S. Armed Forces in Vietnam during the Vietnam era, with Federal and other benefits and services (including, but not limited to, health care and monetary compensation for disabilities which may be related to their experience during their employment), either through the VA or otherwise, and for assisting those individuals in connection with disabilities they may have incurred as a result of their employment in Vietnam. This provision specifies that service in Vietnam under the auspices of such a voluntary organization—such as in the case of one who donated his or her time and effort—would be considered to be employment by the organization.

Paragraph (2) of subsection (a) of section 503 would require the Administrator and the Secretaries of Defense and of Health and Human Services, not later than 180 days after the date of enactment of the Committee bill, to submit to the appropriate committees of the Congress a joint report on the question of U.S. Government responsibility for establishing a program of benefits and services (as described in the above analysis of paragraph (1) of this subsection of the Committee bill) for those employees of voluntary organizations. The report would be required to set forth various alternative approaches, together with comments on the appropriateness and the advantages and disadvantages of each, for establishing such a program and any recommendations that the Administrator and the Secretaries have with respect to those alternative approaches.

Subsection (b) would provide that, for the purpose of this section, the term "Armed Forces" has the meaning set forth in section 101(10) of title 38, namely, "the United States Army, Navy, Marine Corps, Air Force, and Coast Guard, including the reserve components thereof", and the term "Vietnam era" means the periods of time described in section 101(29) of title 38, as proposed to be amended by section 201(a) (discussed above) of the Committee bill, which would encompass the period beginning February 21, 1961, and ending May 7, 1975. Under current law, section 101(29) defines the Vietnam era as the period beginning August 5, 1964, and ending May 7, 1975. As proposed to be amended, this definition would also include the period beginning February 21, 1961, and ending August 4, 1964, in the case of a veteran who served in Vietnam during that earlier period.

Section 503—Costs: Enactment of section 503 is estimated to entail no significant costs.

Section 504

Subsection (a) of section 504 would direct the transfer from the General Services Administration (GSA) to the VA, at no cost to the VA, of a certain parcel of land (including any structures situated on the land on the date of the enactment of the Committee bill) in Phoenix, Arizona, described in subsection (b) (discussed below) of this section of the Committee bill.

Subsection (b) of section 504 would describe the parcel of land which is to be transferred from GSA to the VA as a tract consisting of approximately 3.25 acres which was formerly part of the VA Medical Center in Phoenix but which was declared excess to the needs of the VA in a September 25, 1959, report to GSA.

Section 504—Costs: Enactment of section 504 is estimated to entail no significant costs.

TITLE VI—EFFECTIVE DATES

Section 601

Would provide that the provisions of and amendments made by this Act shall take effect on the date of enactment of the Committee bill except that sections 201 (relating to the definition of Vietnam era), 203 (relating to counseling for former prisoners of war), 422 (relating to contracting for the construction and operation of a nursing home), and 502 (relating to payments for therapeutic and rehabilitation activities) would be effective on October 1, 1985, and section 401, relating to annual VA medical-facility construction authorizations, generally would be effective on October 1, 1986.

RECORD OF VOTES CAST IN COMMITTEE

Pursuant to paragraph 7 of rule XXVI of the Standing Rules of the Senate, announcement is made that the members of the Committee on Veterans' Affairs, at an June 12, 1985, meeting to consider S. 876, unanimously by voice vote, agreed to report S. 876, with an amendment in the nature of a substitute, favorably to the Senate.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

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Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 6, 99th Congress, a bill entitled the "Veterans' Administration Health-Care Amendments of 1985," and Amendment No. 22 to this bill. This bill contains a number of major provisions relating to the VA health-care program.

VA favors section 2 of the bill which would expand the definition of the Vietnam era, and favors the major purpose of section 5 of the bill to extend VA's authorities to contract for halfway house care for veterans with alcohol or drug abuse dependence or disabilities. VA has no objections to section 4, which would extend through Fiscal Year 1989 the special eligibility period for veterans exposed to dioxin or other toxic substances, or to nuclear radiation, to receive VA health care. Finally, we favor Amendment No. 22, which would clarify an ambiguity in the law that now appears to limit readjustment counseling services to certain Vietnam-era veterans after September 30, 1988.

We oppose section 3 of the bill, which precludes the Agency from implementing any systematic reduction of VA employee pay grades without first submitting to the Veterans' Affairs Committees a plan and justification for the proposed reduction. We also oppose both section 7 regarding disclosure of medical quality-assurance records as well as section 8 relating to disciplinary proceedings under section 4110 of title 38, United States Code, involving clinical privileges. Finally, we oppose section 9, which would require VA to conduct a pilot health-care demonstration program and section 10 of the bill, which would direct VA and the Departments of Defense and Health and Human Services to submit a joint report to Congress on providing services to certain civilians who served in Vietnam during the Vietnam era.

First, section 2 of the bill would expand the legal definition of the term "Vietnam era" to include the period from February 21, 1961, through August 4, 1964, if the veteran served in

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Vietnam during that time. VA supports this change in the law. We estimate that approximately 48,000 veterans served in Vietnam between February 21, 1961, the date established in Public Law 89-527 for acceptance of awards from foreign governments for service in Vietnam, and August 5, 1964, the date of the Gulf of Tonkin Resolution. Those veterans served under adverse conditions which can be considered akin to wartime conditions. It is reasonable that they be eligible to receive benefits for which wartime service in general, and Vietnam-era service in particular, is a requirement.

Veterans covered by this provision would become potentially eligible for several benefits. Principally, they could receive nonservice-connected pension benefits if they also meet disability, income, and net worth requirements. Other benefits they might receive include certain burial benefits, readjustment counseling services, medical benefits under Public Law 97-72, and loan guaranty benefits in certain cases. The number of veterans who would be affected and who are not otherwise eligible for these benefits is not large. The estimated cost for these additional benefits is approximately $1.3 million for each of the next five fiscal years.

Section 3 of the bill would prohibit VA from implementing any systematic reduction of Agency employees in any pay grade unless VA first submits to both Committees on Veterans' Affairs, at least ninety days before implementing a reduction, a report containing a detailed plan and justification for the reduction demonstrating that VA has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to equivalent employees in other Federal agencies and non-Federal entities. Furthermore, this section directs the Comptroller General to submit to the committees, within 45 days after the submission of this report, a report on VA's compliance with this provision and an opinion on the accuracy of the Agency's determination.

Section 3 would inject the Congress into a management function, and VA opposes it. Obviously, any steps to control grade levels must be the object of careful study, but the analysis properly can and should be accomplished <u>within</u> an executive agency and not be conditioned upon any report to the committees of the Congress.

We also consider the definition of a grade reduction in section 3 of the bill to be overbroad. Arguably, this definition could be interpreted to require an advance report and determination as to virtually any systematic action which would result in grade reductions. Specifically, it could prevent us from reorganizing work, implementing new classification

standards, complying with classification consistency review requirements directed by Office of Personnel Management, or generally reclassifying positions properly if any of the actions would result in a lower grade structure for any group of employees.

Section 4 would extend for almost three years the eligibility period for certain veterans who were exposed either to dioxin or other toxic substances while serving in Vietnam during the Vietnam era, or to ionizing radiation from nuclear detonation, to receive priority VA health-care services for disabilities not determined to be unrelated to that exposure. Currently, this eligibility period expires one year after the submission of a Congressionally mandated report on the epidemiological study being conducted by the Center for Disease Control (CDC) of the effects of exposure to dioxin on Vietnam veterans. The first report is due 24 months after the protocol for the study was approved, which was on February 24, 1984. Therefore, this health-care eligibility is scheduled to expire on February 24, 1986.

We believe that the necessary information for this study will not be sufficiently advanced by 1986 to permit Congress and the Administration to make final decisions on care for these veterans. The expiration date recommended by this provision--September 30, 1989--is based on the premise that, if, as planned, the CDC reports on the epidemiological study by September 1988, then Congress would have sufficient time to evaluate the results of that study and other relevant information and decide if further action may be needed. This proposed extension would permit Congress and the Administration to have sufficient time to analyze the results of the study and make a decision regarding health care for these veterans prior to the expiration of their eligibility. Thus, we have no objection to this provision. We estimate the cost of this extension to be $69.6 million for Fiscal Year 1987 and for each of the next two fiscal years for a three-year total cost of $209 million.

Section 5 of the bill would extend for three years, until the end of Fiscal Year 1988, VA's current authority to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This authority expires on September 30, 1985. A similar provision was passed by the Senate last year. We strongly support the extension of VA's authority to operate this program and have submitted legislation to extend this authority through Fiscal Year 1988. Our estimated cost for this provision is $6.1 million for each of the next three fiscal years.

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Since April 1980, the VA has operated a program authorized by Public Law 96-22 under which certain veterans suffering from alcohol and drug dependence have been provided treatment and rehabilitation in community contract facilities such as halfway houses. In authorizing its establishment, Congress called for VA to plan and operate a pilot program so as to demonstrate both the medical advantages and cost-effectiveness of this care in contrast to comparable care rendered in VA facilities. Congress also directed that VA report by March 31, 1984, on the operation of this pilot program. The required study indicated that those patients who were placed under this program were, on the whole, least able to cope in society.

VA prides itself on the quality of care of our substance abuse programs. Nevertheless, our study tends to show that, for approximately five percent of VA patients admitted for substance dependence or abuse disabilities who are essentially alienated from society, many without family support and with no job in the community, contract halfway house care with its peer setting can greatly help reentry into the community and acquisition of self-help and job skills. This five percent minority tends to reenter more successfully the job market and the community from halfway house care than from VA hospitals. We have found that the halfway house provides more definitive rehabilitation of recovery-resistant cases requiring continued residential support and extensive work on self-help skills. It also offers economic advantages of shortening the total VA hospital-bed days by providing treatment and rehabilitation in a lower cost residential environment.

As of the end of Fiscal Year 1984, 83 VA medical centers had contracts with 297 non-VA community-based programs, and 16,685 veterans had been outplaced for treatment in these contracted facilities. The program evaluation study revealed strongly encouraging followup measures of maintained sobriety, active roles in Alcoholics Anonymous, and increased employment and monthly income. There are sufficient data on the treatment benefits and cost-effectiveness of contracting for treatment and rehabilitation of these relapse-prone veterans to warrant continued authorization for this program.

This provision would also require the Administrator to submit reports for Fiscal Years 1985, 1986 and 1987 to the Veterans' Affairs Committees on findings and recommendations on the operations of the program. Each report must include information on the average duration of veterans' participation in the program, rates of successful rehabilitation, and any changes in average and maximum allowable charges per veteran under contract. We wish to point out that, while the data on average lengths of stay in contract programs can be collected

directly from the VA medical centers using the contract authority, determining the rates of successful rehabilitation for veterans outplaced in non-VA community-based programs, as required by the bill, would be much more difficult and costly. For example, alcoholic veterans who are to be contacted and assessed for level of recovery and other treatment-related measures are often difficult to locate after discharge from the non-VA halfway houses. During Fiscal Year 1984, 5,770 veterans were outplaced into halfway houses after acute care at VA medical centers.

Section 7 would amend section 3305 of title 38, which generally prohibits disclosure of medical quality-assurance records, to the extent that they are designated confidential by VA regulations. Implementing regulations provide for the release of aggregations of statistical data from quality-assurance studies and reviews except where those statistics would, by implication, reflect on the care and treatment being provided by a particular practitioner. Section 7 of the bill would overrule this regulation by requiring that all quality-assurance mortality and morbidity statistics for specific activities at individual VA hospitals be made public. No exception is provided. If this provision is enacted, the mortality and morbidity statistics (that is, the incidence by percentage of death or disease in a program) in a relatively small, single-provider program, such as cardiac surgery, would be publicly available and would reflect directly on the provider in that program. Particularly in major surgeries, such as cardiac surgery, we believe that an individual patient should be apprised of these statistics as they relate to his or her care. We believe further, however, that the VA quality-assurance review of the small, single-provider program will be seriously and detrimentally affected if such statistics must be made public. Accordingly, we strongly oppose enactment of this provision.

The compilation of mortality and morbidity statistical data reflects medical judgment. For example, when reporting mortality/morbidity statistics for a cardiac surgery program, a death, the underlying cause of which is cardiac surgery, but the immediate cause of which is pneumonia, could be reported as the result of pneumonia rather than complications resulting from the surgery. Such would reduce the cardiac surgery mortality rate. The public availability of this potentially critical data on individual providers will be a factor for consideration by other providers when they exercise their judgment on how to "count" their peer's patient mortality. We believe that this will, in fact, significantly influence the mortality and morbidity statistics reported in small, single-provider programs.

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It should be pointed out that the Agency is currently developing an additional quality-assurance mechanism know as the Peer Review Organization (PRO). It is anticipated that this process will engender provider-specific statistics for all VA physicians. For the aforementioned reasons, we are concerned about the Agency's ability to garner accurate statistics in the PRO process if section 7 of S. 6 is adopted.

We believe that enactment of section 7 of this bill would also detrimentally affect other areas pertaining to patient care that are not related solely to the VA quality-assurance program.

These concerns include the fact that public availability of provider-specific data would have a chilling effect on the ability of the VA to retain physicians and other health care professionals. As you are aware, the performance of private practitioners in the community is not subject to public disclosure. Additionally, we believe that this statistical data could easily be misinterpreted by the veteran. As a consequence, such a veteran may well be dissuaded unnecessarily from seeking appropriate treatment. We are also concerned that surgical mortality rates may become public indicia for assessing the care at a facility. Such a practice could discourage the use of surgery for high risk patients even though it is medically and ethically appropriate.

In considering the need for confidentiality for provider specific statistical data, it should be noted that at least one other Government agency faced concerns similar to VA's and has recently provided protection for such data.

The debate in the private sector has been ongoing for nearly ten years with respect to the release of statistical data collected first by Professional Standards Review Organizations (PSROs), and now PROs, under the Medicare program. The Department of Health and Human Services (DHHS) recently published regulations (to be codified at 42 C.F.R. Part 476) which implement section 1160 of Title XVIII of the Social Security Act (Medicare). These regulations are nearly identical to VA's with respect to release of statistical data. DHHS rules provide that the PROs must disclose nonconfidential information to any person upon request, except aggregate statistical information that implicitly or explicitly identifies individual patients, practitioners, or reviewers.

Finally, we believe that the existing regulatory provision, i.e., 38 C.F.R. § 17.518(b), is adequate because it provides a reasonable balance between the public's need to hold the Agency accountable (e.g., through Congressional oversight) and the need of the Agency to protect the peer review process and the quality assurance program.

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Section 8 of the bill would provide that the procedures set forth in section 4110 of title 38, relating to disciplinary board proceedings involving VA physicians, dentists, nurses, and certain other VA health-care personnel employed under the title 38 personnel system for inaptitude, inefficiency, or misconduct, would also apply to cases involving proposed reductions or revocations in the clinical privileges of these personnel for the same charges. Under this provision, a disciplinary board could not impose a reduction or revocation of clinical privileges unless the person charged has been provided notice prior to the hearing and the reduction or revocation is on the basis of deficiency in clinical practice.

We believe that privileging is a clinical management function for quality patient care and for accreditation as required by the Joint Commission on the Accreditation of Hospitals (JCAH). Recognizing this, the Department of Medicine and Surgery (DM&S) has appointed a Director for Quality Assurance who reports to the Chief Medical Director and whose office will work with VA medical centers to review the quality of their clinical privileging program.

We also believe that a disciplinary board proceeding is not the proper forum for the review of clinical privileges. In our view, the authority to decide on clinical privileges should remain with the facility's chief of staff, aided by local peer review through a professional standards board. Policies and procedures on approval and review of clinical privileges are included in each VA medical center's bylaws as required by the JCAH. JCAH requires that the bylaws include provisions for (1) a fair hearing, and (2) appellate review in the event of a recommendation adverse to the employee/ applicant. Typically, the VA facility implementation is a peer review process with a hearing and appeal available where there has been an adverse determination. The Associate Chief Medical Director for Quality Assurance will be issuing guidance emphasizing these process requirements.

Generally, however, the review and delineation of clinical privileges is a joint cooperative process with the employee seeking approval of proposed privileges. It is designed, and in the vast majority of cases operates, to protect against arbitrary withdrawal of privileges, without sacrificing the overriding priority, which is the well-being of VA patients.

This proposal would remove this decision-making authority from the local facility and vest it with the Chief Medical Director, with appeal to the Administrator. Not only would this change have substantial operational consequences with a substantial loss in flexibility; but more significantly, it

Honorable Frank H. Murkowski

could result in a sacrifice of the confidentiality essential for effective quality assurance oversight. Discipline under section 4110 concerns a professional's employment status and is based on culpable inaptitude, inefficiency and/or misconduct. The privileging process concerns the capacity to treat patients and is based on an individual's clinical competence in a particular hospital activity as the result of his or her professional training and experience. These proposed new procedural requirements could delay the withdrawal of clinical privileges even if the health and safety of veteran patients were threatened. We believe these processes, the privileging on the one hand, and the disciplinary on the other, are properly separate and should remain separate. We strongly oppose this provision.

Section 9 of this bill would require VA to conduct a 48-month pilot demonstration program in at least 5 geographic regions through which participating veterans would receive appropriate health and health-related services such as homemaker, personal care, and transportation services, from VA and appropriate public and private agencies. The express purpose of this program is to enable VA to evaluate the effectiveness, feasibility, and desirability of various actions that would provide veterans needed care in noninstitutional settings. VA would be required to report to Congress on the results of this program, with recommendations for appropriate administrative and/or legislative action, no later than 39 months following the commencement of the program. Section 9 calls for an authorization up to $10 million for this program for Fiscal Year 1987 and such sums as may be necessary for each of the subsequent four fiscal years.

VA favors the basic concept of developing alternatives to institutional care. We have submitted draft legislation to Congress which would establish a pilot program to provide veterans with an alternative to nursing home care by authorizing VA to conduct a three-year pilot test of respite care. VA also has several other programs to achieve these purposes, including adult day health care and hospital-based home care as alternatives to institutional care. Accordingly, we see no need for this provision.

Although section 9 would provide VA with the means to evaluate the benefits of providing new health-related services, the provision is unduly prescriptive in directing the scope and operation of the pilot program. We see no need for Congress to mandate minimum numbers of geographic areas or VA geriatric evaluation units to be included, for example. In many respects, the requirements of section 9 are so specific that they deprive VA of the latitude needed to derive real benefit from any such pilot program.

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Finally, we cannot favor this provision because of the projected additional costs of a new program as contrasted with existing demands on VA resources. The respite care program, for example, would not entail any additional funds because it would be conducted at VA facilities using available resources. However, the estimated cost of the program proposed under section 9 of the bill would be $4.3 million for Fiscal Year 1987 and $5.7 million for each of the next three fiscal years. We cannot justify the shifting of resources from our existing facilities and ongoing programs in order to establish this pilot program.

Section 10 of S. 6 would direct VA and the Departments of Defense and Health and Human Services to submit a joint report to Congress on alternatives whereby the Government might provide services, such as health-care and monetary compensation for disabilities incurred, to Government employees and other civilians who served in Vietnam during the Vietnam era. We oppose this provision for several reasons. First, Title IV of Public Law 95-202 established a means for members of civilian support elements to apply to the Secretary of Defense for recognition of alternative service to establish veteran status. Second, we are unaware that civilians who served in organizations, like the Red Cross, are in such need of assistance for health insurance or other benefits, beyond what their own organization may provide, as to warrant Federal aid. We therefore do not believe it would be prudent to expend funds of the United States Government to conduct an extensive study on a potential problem where there appears to be little evidence that a real problem exists.

The provisions of Amendment No. 22 to S. 6, which is characterized as a technical and conforming amendment, would amend section 612A(g) of title 38, United States Code, to remove three words which appear to limit the provision of readjustment counseling services after September 30, 1988, to veterans who requested such services before that date. With the enactment of Public Law 98-160, Congress specifically deleted from section 612A(a) of title 38 language which had provided that, to receive readjustment counseling services, an otherwise eligible veteran had to request those services within two years after the date of the veteran's discharge from active duty, or by September 30, 1984, whichever was later. However, subsection (g) of section 612A, which contained language listing such counseling to veterans who request it by September 30, 1988, was not amended. The amendment to section 612A in Public Law 98-160 does create some ambiguity as to whether Congress intended to retain a delimiting date for requesting counseling. The proposed amendment would clarify the matter and would be helpful. Accordingly, we favor the provision.

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We do not believe enactment of this provision will have a significant budgetary impact.

We estimate the costs of this bill to be $7.4 million for Fiscal Year 1986 and $255 million for the first five fiscal years.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Rowe Jr.
Deputy Administrator • Fot

HARRY N. WALTERS
Administrator

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

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Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 1052, 99th Congress, a bill entitled the "Veterans' Chiropractic Services Demonstration Projects Act of 1985." Based on professional, programmatic, and budgetary concerns, we oppose enactment of this bill.

This bill would require VA to conduct five "demonstration" projects over a three-year period to evaluate the therapeutic benefits and cost-effectiveness of furnishing chiropractic services to veterans. It would direct that, in developing the projects, VA enter into cooperative agreements with chiropractic colleges to perform jointly clinical research on the question of benefits and cost-effectiveness, and to undertake jointly certain unspecified "coordination" of chiropractic services to eligible veterans. S. 1052 also describes a class of veterans eligible to be reimbursed for chiropractic services under the demonstration projects.

Furthermore, the bill directs VA to provide reimbursement in accordance with a schedule of charges established by the Administrator in consultation with other Federal agencies and public and nonprofit organizations that reimburse for chiropractic services. The proposed VA schedule of reasonable charges is to be "consistent" with the reasonable charges allowed under the Medicare program, but reimbursements to individual veterans could not exceed $600 per year. The overall appropriation authorized by this bill for chiropractic services (but not for other elements of this bill such as required research) is $2 million per fiscal year. Unless later extended, no reimbursement under the bill's demonstration projects could be made after September 30, 1987.

The concept of conducting a demonstration project, as proposed in S. 1052, is premised on the notion that one would intend to establish a permanent program based on the "success" of the demonstration. We strongly recommend against establishing such a program. We believe that it is important to note that a

Honorable Frank H. Murkowski

requirement that VA provide or reimburse for chiropractic services would represent a fundamental change in the function, focus, and orientation, and potentially in the structure, of the VA health care system. This bill is presumably based on the premise that the VA presently lacks the ability to provide a full range of quality care and services to eligible veterans. We reject that premise.

The VA is required by law to provide a complete hospital and medical service for the care of veterans and to employ the services of licensed physicians who hold a degree of doctor of medicine or osteopathy from a college or university approved by the Administrator. The therapeutic capabilities of the existing VA medical staffs and consultants are comprehensive and flexible, and fully meet the needs of all veteran patients. We strongly believe that disorders of the musculoskeletal system are skillfully and appropriately treated in the VA by physicians, medical and surgical subspecialists, and specialized support personnel. Therefore, because of the strengths and capabilities of the VA health care system to provide this treatment, we frankly do not see a role for chiropractic in that system.

Unlike Medicare and other systems, VA's health care system is primarily a provider of care, not a passive reimbursement mechanism, and Congress has clearly delineated and limited the circumstances under which fee-basis or contract care may be authorized. Other than in certain emergencies, the law does not permit VA to reimburse for fee care at all unless VA physicians have determined in advance that care is needed and have authorized it. This bill, on the other hand, does not provide a satisfactory mechanism to assure that there is a need for such services.

Moreover, while it is not our intention to rekindle debate over the scientific or therapeutic validity of chiropractic care, our efforts to study the available literature have revealed little evidence that chiropractic schools or the chiropractic industry at large has conducted significant scientific research regarding the efficacy of chiropractic. We question then why VA should be asked to undertake an effort, as proposed in this bill.

Enactment of S. 1052 would require expenditures far in excess of the $2 million limit on direct payments for chiropractic services. Meeting the bill's requirement that VA participate in clinical research and data collection to evaluate the therapeutic benefits and cost effectiveness of providing chiropractic services to veterans is likely to cost at least $7 million. We would envision the need to design a study that

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would compare chiropractic with other forms of therapy. From a purely scientific point of view, this would be a very complex undertaking. Establishing the health problems to be studied and recruiting sufficient numbers of patients to obtain statistically significant data would both prove very difficult. Equally troublesome would be establishing the effectiveness of treatments. For example, there are simply very few objective measures for determining improvement of low back pain, one of the most common musculoskeletal problems.

We wish to emphasize that VA does not wish to limit the freedom of choice for a veteran as a health-care consumer. Veterans, of course, have freedom of choice in their selection of health care providers and modes of care. We also know that many eligible veterans, for a variety of reasons, do not routinely obtain their care from VA. Some may seek care from sources outside the medical profession. However, we do oppose any attempt to redesign inadvertently the VA health care system in an effort to increase further a veteran's choices for health care, such as for chiropractic services in the veteran's community at VA expense.

Finally, it must be noted that VA has the challenge of meeting its existing mission in the face of fiscal constraints. Accordingly, we would hope to avoid the imposition of new requirements, such as provided for in this bill, that would oblige VA to divert scarce resources. For these reasons, we strongly oppose this legislation.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Rogers / Deputy Administrator • For

HARRY N. WALTERS
Administrator

Office of the
Administrator
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Washington DC 20420

Veterans
Administration

June 11, 1985

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 875, 99th Congress, a bill "To amend title 38, United States Code, to require the Administrator of Veterans' Affairs to establish and carry out a Vietnam Veterans' Resource Center pilot program." VA opposes enactment of this bill.

S. 875 would establish a three-year pilot program to convert the mission of ten of the VA's readjustment counseling centers (Vet Centers) into facilities tasked to provide on site a variety of services to Vietnam-era veterans who are eligible for readjustment counseling. The centers, which would be known as Vietnam Veterans' Resource Centers, would continue to provide eligible veterans with readjustment counseling and related mental health services, and would additionally provide drug and alcohol abuse treatment and rehabilitation; employment counseling, training, placement services, and veterans benefits outreach services. The bill provides that veterans eligible to receive services at the new centers would be limited to those now eligible for readjustment counseling services.

Administration of the pilot program in the ten new resource centers would be under the Deputy Administrator of Veterans Affairs. The "Team Leader" in each of the Vet Centers designated to become resource centers would become the Resource Center Director. The staff of each resource center would also include other persons now working in the Vet Center, personnel experienced in career development and vocational rehabilitation and counseling, one or more Veterans Benefit Counselors; and personnel experienced in drug or alcohol abuse treatment, counseling and rehabilitation. The bill would also authorize the Secretary of Labor to assign disabled veterans outreach program specialists to the centers.

The concept of converting some Vet Centers into expanded one-stop service centers has a certain appeal. Nevertheless, we see serious problems in both the concept as well as the

Honorable Frank H. Murkowski

specific provisions of the bill. Foremost among our concerns is that the proposal would move the Vet Centers in the direction of a self contained system autonomous from the larger VA system. We believe the readjustment counseling program has greatly improved, in part through VA having achieved greater integration and coordination between that program and the overall VA system. We believe that the direction we have taken with that program offers the greatest capacity to assist veterans.

In contrast, the approach proposed by S. 875 would be very costly to establish, manage, and evaluate. We do not believe that the experience we might gain from operating such a pilot program would outweigh the costs, particularly in light of other demands on these resources. Finally, we believe that Vet Centers are already successfully carrying out many of the functions which this bill would mandate and we see little reason to conduct an experiment of this magnitude.

It is important to understand that many Vet Centers now provide a combination of services to the veteran associated with readjustment counseling. In that connection, we note that 120 Vet Centers now have a Department of Labor employee working at the Vet Center on a regular basis for a set number of hours per week performing employment counseling. In addition, a number of Vet Centers have an employee from the Department of Veterans Benefits working regularly to provide benefits counseling. In a few instances, substance abuse counseling is provided if the Vet Center counselor on staff has the necessary qualifications to provide such counseling. We strongly believe that local program managers should be left with the discretion to provide the services they deem necessary in the most effective and efficient manner possible. It may be more difficult and more costly to provide services outside the medical center or regional office setting, and we do not believe broad based service delivery by Vet Centers should be mandated. One major reason for the success of the Vet Centers over the past five years has been the sharp focus of their mission. We believe that the pilot program would tend to diffuse that mission and thus not take account of an important lesson that has been learned. Finally, separate and apart from the merits of the pilot program, we are uneasy with the organizational scheme under which such a program would be administered.

VA estimates the cost of S. 875 to be $2.8 million in the first fiscal year and $6.7 million for the three years that the pilot program would be conducted.

Honorable Frank H. Murkowski

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Deputy Administrator • For

HARRY N. WALTERS
Administrator

Enclosures

PROJECTED COST OF THE RESOURCE PILOT PROGRAM 5/28/85
(Bill S.875)

SUMMARY

Salary (recurring)-------- $1,471,740

All-Other (recurring)------ 348,410

All-other (non-recurring)-- 945,000

Total FY 86 ---------- $2,765,150

Total FY 86 Travel-------- $ 25,000

Total FY 87---------- $1,820,150 (minus non-recurring start-up cost)

Total FY 88---------- $1,365,113 (minus non-recurring cost and 25% reduction)

Total FY 89---------- $ 670,292 (minus non-recurring cost and 50% reduction)

SEE ATTACHED CHART (next page)

49-326 O—85——6

VETERANS ADMINSTRATION 5/28/85

VIETNAM VETERANS RESOURCE CENTER PILOT PROGRAM

MEDICAL CARE

(dollars in thousands)

Resource Requirements for FY	1986	1987	3/ 1988	4/ 1989
Obligations				
Vet Center Pilot Program				
Salary Cost (recurring) (12.5% employment benefits)	1,471,740	1,471,740	1,103,805	539,638
All-Other (recurring)	348,410	348,410	261,308	130,654
All-Other (non-recurring)	945,000	0	0	0
Total	$2,765,150	1,820,150	1,365,113	670,292
Travel (.007) 1/	25,000	25,000	18,750	9,375
Program Details				
Average Employement(FTEE) 2/	60	60	45	22
Number of V.V.R.C	10	10	7	3

1/ Average travel cost per Vet Center ($1,000 / X = 4 / 10)

2/ Additional ftee (6 additional hires at each of the 10 sites)

3/ Legislation for this program is being proposed for a period of three-years. The budget outyear (1988) would be reduced by 25%.

4/ This budget outyear (1989) would further reduce the program funds by 50%.

Non-recurring

All-other non-recurring start-up cost are based on the average existing Vet Center expense.

NOTE:

Vet Center relocation----------	$20,000 x 10 =	200,000
Vet Center renovation----------	3,000 x 10 =	30,000
Vet Center furnishing----------	1,000 x 60 =	60,000
Vet Center equipment----------	1,500 x 10 =	15,000
Vet Center personnel relocation—	10,000 x 60 =	600,000
Vet Center handicapped access——	4,000 x 10 =	40,000

Total non-recurring cost $945,000

Travel cost:

$1,000/x = 4/10

4x = 10,000

x = 10,000 / 4

x = 2,500

2,500 . 10 = $25,000

PROJECTED COST OF THE RESOURCE PILOT PROGRAM

Program Requirement:

10 selected existing Vet Centers

6 additional employees at each selected site.

Cost:

Recurring

Salary cost is based on the average grade level of a GS9 step 1 ($21,804), plus retirement, social security and medicare. All salary cost projected by the present 12.5% employment benefits..

NOTE: GS9/1 $21,804 x 12.5% = 24,529 (includes all benefits)
24,529 x 6 = 147,174 (one site)
147,174 x 10 = 1,471,740 (ten sites)

Total salary cost $1,471,740

All-Other recurring cost is based on current four-person cost to include six additional employees as shown:

RENT---------- $16,864 x 10 = 168,640
UTILITIES---------- 4,494 x 10 = 44,940
OFFICE OPERATIONS--- 11,236 x 10 = 112,360
SUPPLIES & OTHER---- 2,247 x 10 = 22,470

Total all-other cost $ 348,410

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

June 11, 1985

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 876, 99th Congress, a bill "To amend title 38, United States Code, to establish, extend, and improve certain Veterans' Administration health care programs." VA opposes enactment of this bill.

S. 876 contains five distinct provisions. Section 2 of the bill would require VA to conduct a pilot program to furnish eligible veterans with medical and social services which would obviate the need for nursing home care. VA opposes this provision. Section 3 would extend, without limit, the VA's authority to contract for care, treatment and rehabilitation services in halfway houses and other facilities for veterans suffering from alcohol or drug dependence or abuse disabilities. VA favors a three-year extension of this authority, but we oppose this provision which would permanently authorize the program. Section 4 would require VA to conduct a pilot program to furnish, by contract, community residential care to chronically mentally ill veterans. VA opposes this provision. Section 5 would mandate that the Administrator establish and conduct a medical quality assurance program. VA opposes this provision because an excellent quality assurance program now exists. Section 6 would establish an advisory committee to make recommendations to the Administrator on medical facility planning. VA opposes this provision.

Section 2 of the bill would require VA to conduct a three-year pilot program in five geographic areas to furnish eligible veterans with medical, rehabilitation, and social services which would obviate the need for nursing home care. The program would commence on January 1, 1986. The bill contemplates that VA would provide these services by contract with public and private providers where available, or if that were not feasible, the VA could directly provide health related and supportive services. Veterans eligible to receive services would be those who would otherwise be receiving care in community nursing homes and who, as a result, would be able to reside at home. The measure calls for VA, in administering the program, to give priority to veterans over 65 years of age and those who are catastrophically disabled. Under the proposal, the cost of carrying out this pilot program in any

fiscal year could not exceed 60 percent of the cost that the VA would have incurred if we had instead furnished community nursing home care to the participating veterans.

Congress provided, in 38 U.S.C. § 4101, that "[the] primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service." That mandate has generally been viewed as contemplating that VA will provide veterans with all needed medical services, either in VA operated facilities or, where necessary, in facilities for which the VA contracts. This mandate clearly excludes the provision of nonmedical social or supportive services which this proposal contemplates. Providing such VA assistance as homemaker or chore services, as proposed, would in part duplicate the assistance for which the basic aid and attendance allowances are currently paid to many veterans under 38 U.S.C. § 314(r)(1). Basic aid and attendance allowances are paid to eligible veterans so they may obtain nonprofessional help to meet such basic needs as feeding, washing and dressing themselves. Moreover, in many communities these services are already available to those who would otherwise need nursing home care. Provision of these services by the VA directly or under contract as contemplated by the law would duplicate these services.

Nevertheless, VA favors the basic concept of developing alternatives to institutional care. For example, we have submitted draft legislation to Congress which would authorize VA to conduct a three-year pilot test of "respite care." Under this proposal, VA would be authorized to furnish care at a limited number of facilities to chronically ill veterans who have the highest claim to VA care--service-connected disabled veterans--who have been receiving hospital based home care. The purpose of this proposal is to give brief, planned periods of respite to members of the veteran's household who would otherwise be rendering care in the home. This pilot program would provide a basis for our evaluating the efficacy of the "respite care" concept in avoiding or delaying the need for prolonged institutionalization and its potential for cost avoidance. The respite care pilot program would only require use of existing VA funds and would be targeted at the service-disabled veteran. Under our proposal, respite care would be furnished in existing operating beds with placements based on local needs assessments and resource availability.

We, of course, have several other programs, such as the adult day health care program and the hospital based home care program, which have long been recognized as providing important alternatives to institutional care. The VA also has broad

authority already to conduct an evaluation of its noninstitutional treatment programs. Accordingly, we see no need for this provision and view the provision as unduly prescriptive in directing the scope and operation of the pilot program. In many respects, the requirements of section 2 are so specific that they would deprive VA of the latitude needed to derive real benefit from any such pilot program.

In addition, we do not favor this provision because of the projected additional costs of a new program as contrasted with existing demands on VA resources. The respite care program, for example, would not entail any additional funds because it would be conducted at VA facilities using available resources.

We estimate the cost of this pilot program to be $3.1 million for each of the next five fiscal years for a total five-year cost of $15.5 million.

Section 3 of the bill would extend without limitation the VA's authority to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. The existing authority for VA to operate this program expires on September 30, 1985. We strongly support extension of VA's authority to operate this program, but we do not at this time support making the authority permanent. We recommend that the program be extended for three years and we have submitted legislation to extend the authority through Fiscal Year 1988.

Since April 1980, the VA has operated a program authorized by Public Law 96-22 under which certain veterans suffering from alcohol and drug dependence have been provided treatment and rehabilitation in community contract facilities such as halfway houses. In authorizing its establishment, Congress called for VA to plan and operate a pilot program so as to demonstrate both the medical advantages and cost-effectiveness of this care in contrast to comparable care rendered in VA facilities. Congress also directed that VA report by March 31, 1984, on the operation of this pilot program. The required study indicated that those patients who were placed under this program were, on the whole, least able to cope in society.

VA prides itself on the quality of our substance abuse programs. Nevertheless, our study tends to show that, for approximately six to eight percent of VA patients admitted

for substance dependence or abuse disabilities who are essentially alienated from society, many without family support and with no job in the community, contract halfway house care with its peer setting can greatly help reentry into the community and acquisition of self-help and job skills. This six to eight percent minority tends to successfully reenter the job market and place in the community better from halfway house care than from VA hospitals. We have found that the halfway house provides more definitive rehabilitation of recovery resistant cases requiring continued residential support and extensive work on self-help skills. It also offers economic advantages of shortening the total VA hospital-bed days by providing treatment and rehabilitation in a lower cost residential environment.

As of the end of FY 1984, 83 VA medical centers had contracts with 297 non-VA community based programs, and 16,685 veterans had been outplaced for treatment in these contracted facilities. The program evaluation study revealed strongly encouraging followup measures of maintained sobriety, active roles in Alcoholics Anonymous, and increased employment and monthly income. There are sufficient data on the treatment benefits and cost-effectiveness of contracting for treatment and rehabilitation of these relapse prone veterans to warrant continued authorization for this program.

Section 3, however, would also require that the Administrator very closely monitor the operation of the program, collect an inordinate amount of statistical data for each and every contract facility, and annually report this data to the Congress. Specifically, VA would be required to collect data for each contract facility (there are 309 presently) on the level of success, rate of successful rehabilitation, the rate of readmission, the ability of the program to aid veterans in transition back to the community, the average cost per veteran, and the appropriateness of such cost when contrasted with costs in other community based programs.

We have no objection to providing Congress a report in light of the further experience we gain with the drug and alcohol halfway house treatment program aimed at assessing the continued usefulness of the program and determining if permanent extension of the program would be warranted. We object, however, to the requirement of the bill that we collect very specific and detailed data for each contract facility, aggregate it in Central Office, and report it all to the Congress. First, such data can be very misleading and not very useful since the number of veterans being treated in any given facility is generally not large enough to make a statistically significant assessment of the

program. For example, if only two veterans are being treated in a given facility, and only one is successfully rehabilitated, those data suggest a 50% failure rate. In fact, the facility may have a better success rate when all patients are considered, both veterans and nonveterans. Moreover, we must object in general to the imposition of voluminous data collection and reporting requirements. Thus, we object to the provisions mandating that we collect, aggregate, and report statistics which may be of questionable validity.

We estimate the cost of continued operation of the program and of meeting the reporting requirements of the provision to be $6.4 million in each of the next five fiscal years for a total five-year cost of $32 million.

Section 4 of the bill would amend section 630 of title 38, United States Code, to mandate the establishment of a three-year community residential care pilot program for chronically mentally ill veterans. The bill would require the establishment of a program, conducted in five geographic areas, under which VA would contract for "care" to be furnished in community residential facilities. The measure would limit VA placements into such program to chronically mentally ill veterans who, but for receiving care in a community residential facility, would otherwise receive VA inpatient care and by virtue of participation in the program eventually would be able to reside at home. The bill would mandate that the program involve the use of VA psychiatric day treatment and hospital based home care programs and that administering facilities employ "unified case management services."

Section 4 of the bill appears to simply expand the VA's existing Community Residential Care Program (CRC), by allowing VA, on a pilot program basis, to pay for the cost of residential care for one group of veteran patients, the chronically mentally ill patients. Enacting such a measure would seriously damage the Community Residential Care Program, and, accordingly, we cannot support the proposal.

Under the existing Community Residential Care Program authorized by 38 U.S.C. § 630, VA, in essence, inspects and accredits residential care facilities, and refers patients to those facilities. VA does not, however, pay for this nonmedical residential "care". The fact that the veteran rather than the VA, pays those costs is in keeping with the general statutory mandate that the Department of Medicine and Surgery provide veterans with all necessary hospital and medical services, but not with nonmedical social or supportive services, as discussed in our comments on section 2 of

this bill. That section would establish a pilot program to be an alternative to nursing home care and it would also involve provision of supportive services. We reiterate our earlier comments that other veterans' benefit programs, and other programs in the community, should be the principal mechanisms by which nonmedical support services are provided to veterans.

We estimate the cost of this pilot program to be $9.4 million in fiscal year 1986, and $39.2 million for the three-year life of the program.

Section 5 of the bill would mandate that the Administrator establish and conduct a comprehensive medical quality assurance program to monitor the quality of health care furnished by the VA. Under the proposal, the Department of Medicine and Surgery would conduct the quality assurance program and the Office of the Inspector General would be charged with monitoring the overall operation of the program. Given the VA's record of performance in this area, we see no need for legislation such as section 5.

We in the VA attach great importance to the quality of care provided to our veteran patients. It is our belief that any objective evaluation of the quality of care available in the VA system would lead one to conclude that eligible veterans can avail themselves of service in the VA confident that such service is safe, effective, and professionally competent. To assure that fact, we are committed to the maintenance and continued improvement of an effective medical quality assurance program, and require that a comprehensive peer review based program exist in every VA medical facility. VA's program is mandated by, and governed by regulations which are formally published at 38 C.F.R. §§ 17.500-17.540. The primary elements of the VA quality assurance program, known as the Health Services Review Organization (HSRO), generally encompass the measures which the Joint Commission on the Accreditation of Hospitals (JCAH) requires for a facility to be accredited. As you know, it is the policy of the VA that all medical facilities in our system comply with the accreditation requirements of the JCAH. Additionally, VA facilities are monitored by, and often accredited by, numerous other federal regulatory agencies, professional associations, and accrediting bodies including the Nuclear Regulatory Commission, the American Association of Blood Banks, and the College of American Pathologists, to name but a few.

There are numerous other mechanisms to assure that quality care is provided in VA health care facilities. Many of our medical centers are affiliated with medical schools, giving

patients the benefit of that added resource. Many advisory boards and committees monitor various aspects of VA health care. Additionally, the Congress, both directly and through the GAO, regularly audits and reviews clinical programs for effectiveness and efficiency. Finally, we are currently implementing a Medical District based peer review program which will add another dimension to the quality assurance system. Computer assisted analyses of medical records and other existing and planned data bases will enable groups of specially selected VA physicians in each Medical District to monitor clinical activities at each facility, making judgments of quality based on specially developed standards and criteria, forwarding essential feedback to colleagues who are determined to keep pace with constantly improving standards of care.

The proposal would require that the Administrator delineate the responsibilities of the Office of the Inspector General (IG) and the Department of Medicine and Surgery (DM&S) with respect to monitoring, evaluation, and conduct of the VA's quality assurance program. We believe those respective roles have been well established under the Administrator's existing authority to delineate those responsibilities. As stated above, existing regulations, which were established by the Administrator, now mandate that the conduct of a program to monitor and evaluate the quality of care is a function to be performed by health care professionals in DM&S. It is also clearly the function of the Inspector General's office, as part of the auditing function vested in that office by the Inspector General Act, to make certain that a quality assurance program exists, and that the required procedures in that program are being correctly followed.

The bill would also direct that the Administrator allocate to the Inspector General necessary resources and personnel with appropriate qualifications necessary to review quality assurance programs. Resources are, and should continue to be, allocated in the normal budgetary process. We do not believe there has been a problem with allocation of resources to the Inspector General. The Inspector General Act grants authority to the IG to appoint personnel, including those with special qualifications as deemed necessary. That function is now being carried out by the IG without problems, and we do not believe a provision directing the Administrator to allocate personnel to the IG is necessary or appropriate, particularly when it could be construed as redundant vis a vis the Inspector General Act.

We also oppose the provision of section 5 which would mandate that the Administrator allocate sufficient travel funds to enable the Department of Medicine and Surgery to carry out its

quality assurance function. Travel funds are, and should continue to be, allocated in the normal budgeting process. The effect of this provision would be, in essence to state in law that quality assurance activities have a greater need for travel dollars than all other DM&S activities requiring travel, and that already scarce travel funds must be allocated to that program regardless of other needs. We submit that such a provision is potentially deleterious.

The bill would also require that DM&S establish mortality and morbidity rate norms for all surgical programs in the VA, and then collect data on actual mortality and morbidity rates to compare with the expected rates. Additionally, the bill would require that data be collected regarding factors which would affect such rates, including characteristics of the patient population, the level of risk involved in the procedure based upon patient age, the kind of illness involved, and the severity of the illness. Under the bill, the Chief Medical Director would be required to contrast mortality and morbidity rates for "each surgery program" with the norms, and determine if deficiencies in the quality of care exist. The Inspector General would be required to review and report to the Congress on the comparison between actual rates and the mortality and morbidity norms.

The language of this provision, and accordingly the task imposed on VA, is unclear. The bill would have VA focus a major part of its quality assurance program on mortality and morbidity for each surgery program including, but not limited to, each cardiac surgery program. The term "surgery program" does not have widespread use in the VA. We do have designated "surgery programs" in three areas, cardiac surgery, renal transplant surgery, and heart transplant surgery. All other surgical procedures are carried out by specialty, e.g. thoracic surgery or urological surgery. If the bill is intended to impose the requirements pertaining to mortality and morbidity only on the three designated programs, the task could perhaps be technically accomplished without undue difficulty. On the other hand, if the intent of the bill is that mortality and morbidity rate norms be established for every surgical procedure, and data be collected on every procedure performed in every VA facility, the task would be monumental.

If we assume the bill requires establishment of norms, and collection of mortality and morbidity rates for all surgical procedures, we must be prepared to undertake an extremely costly and time consuming effort which would produce results which would be of very questionable value. Contrasting mortality and morbidity rates with rate norms is not a

definitive method for determining quality of care. Many factors affect mortality and morbidity statistics such as age, economic status, health status, and patient referral patterns. Only qualified professionals have the training to evaluate those factors. Weighing the uncertain benefits of this proposal against the extraordinary costs it would impose, we urge the Committee to reject it. We believe other more conventional quality assurance mechanisms now in existence can make better use of surgical mortality and morbidity data. For example, physicians in VA hospitals, as part of the existing quality assurance program, conduct mortality/morbidity conferences. Such conferences are but one mechanism in the overall VA quality assurance program. The physicians meet, on a periodic basis, to review mortality and morbidity for surgical procedures. Typically, the conference might review a sampling of the records of all patients who underwent a specific surgical procedure during a specific time period. Such reviews, conducted by physicians who understand the meaning of mortality and morbidity data, and who are best able to assess that data, are a far more cost-effective and useful method for reviewing mortality and morbidity than the method proposed in this bill.

Finally, the bill would require that annually, the Inspector General's office should review the actual mortality and morbidity rates, contrast those rates with the established norms, and report the results of the review to the Congress. The Inspector General's office now performs cyclical audits of all VA medical centers at least once every three years. As part of such audits, that office would, if this bill were enacted, review mortality and morbidity statistics and contrast them with the established norms. Generally, this would be done as a sampling to make certain that the quality assurance mechanism is being conducted. However, we strongly oppose this provision if it is intended that the Inspector General annually review all morbidity and mortality rates for all procedures in all VA facilities, and then report the results to the Congress. Such a task would be an extraordinary effort in terms of cost and time, especially since the utility of the effort would be so questionable. We again reiterate that quality assurance should be a normal function of the medical staff, as it now is in the VA. It should not be converted into a mechanism used mechanically to attempt a centralized oversight function.

We estimate the cost of this proposal to be $7.4 million in each of the next five fiscal years for a total five-year cost of $37 million.

Section 6 of the bill would require the Administrator to establish an Advisory Committee on Veterans' Administration Facility Planning, consisting of members of the public

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including individuals with expertise in pertinent health care policy and planning, clinical practice, and medical facility construction and veterans' representatives. The Secretaries of Defense and Health and Human Services and the VA's Chief Medical Director would be ex officio members of the Advisory Committee. The committee would be charged with reviewing and evaluating the VA's criteria for sizing VA medical facilities including methods for determining such criteria. In that connection, the committee would be required to evaluate access by veterans to the VA health care system, and they would develop recommendations for modification of sizing criteria. Annually, the committee would report to the Administrator who would in turn transmit the report with comments and recommendations to the Committees on Veterans' Affairs.

We oppose this provision. The establishment of an advisory committee is but one of several possible vehicles for an agency to obtain advice or expertise from outside the Government. We see no justification or need at this time for reliance on this particular advisory vehicle. Its work would be duplicative of major efforts taken by the Agency, and its establishment is unnecessary. We presently use a bed-sizing model developed jointly by VA and GAO under a congressional mandate, to "size" VA-planned medical facilities. The model is considered a state-of-the-art methodology and is constantly being evaluated and refined as appropriate. VA staff are assigned to VAMC Gainesville to work in conjunction with the University of Florida to improve the model and to make adjustments to the model to incorporate new policy developments such as the VA resource allocation methodology. There is a standing advisory group of experts on operations research, modeling and health care from other federal agencies and from the academic community who provide consultation to the project staff.

Thus the purpose this provision is intended to accomplish is already being met. We estimate the cost of the advisory committee would be insignificant.

We estimate the costs of the whole bill to be $26.4 million for fiscal year 1986 and $124 million for five fiscal years.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez, Jr. Deputy Administrator • For

HARRY N. WALTERS
Administrator

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 12 1985

Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 1007, 99th Congress, a bill "To amend title 38, United States Code, to direct the Administrator of Veterans' Affairs to develop and carry out a pilot program to determine the most cost effective methods of acquiring medical facilities to meet the needs of the Veterans' Administration and otherwise to promote additional health care for eligible veterans, and for other purposes."

The major provisions of S. 1007 would require the following:

(1) that for new or replacement medical facilities, VA must generally give first consideration to leasing or buying an existing facility;

(2) that VA implement a pilot exercise involving the acquisition and operation of medical facilities through specified mechanisms and funding limitations to determine the most cost effective method of acquiring medical facilities; and

(3) that VA report to the Congress estimating the cost, and resultant savings due to decreased construction, of increasing the number of community nursing home beds available to the VA by 50% and 75% respectively.

As discussed in more detail below, we do not believe that implementation of the proposed pilot program represents an effective means of achieving the apparent desirable purposes sought. Accordingly, we oppose this measure.

Section 2 of the bill would amend 38 U.S.C. § 5002 to require the Administrator, when planning for a new or replacement medical facility, to give first consideration to leasing or purchasing an existing facility if such a facility exists, if it meets VA needs, and if it would be more

cost effective to acquire and operate the facility than to construct a new one. VA now has the authority to acquire existing medical facilities by either purchase or lease. It is our view that if an existing facility meets VA needs in terms of location, size, condition, VA standards, susceptability to needed adaptation, and long term, life cycle cost-effectiveness, then such a facility should be either purchased or leased in lieu of construction of a new facility. Certainly, if those conditions were met, VA could and would, under existing law, give priority consideration to acquisition of the existing facility rather than construct a new one.

As presently worded, its enactment could have unintended effects. Mandating by statute that VA give first consideration to the purchase or lease of existing facilities could spark unwarranted pressures on the VA to acquire specific facilities and give rise to time-consuming challenges to VA determinations that a facility does or does not meet VA needs, that it could or could not be adapted or operated in a cost-effective manner, or that it is better than other existing facilities. Such challenges could result in delays or added costs in obtaining needed new VA health care facilities. Finally, therefore, we recommend deleting the word "first" and adding "consideration of other costs and factors which the Administrator finds are relevant."

Section 3 of the bill would mandate that VA undertake a pilot program aimed at determining the most cost-effective method of acquiring various types of health care facilities. Under the pilot program VA would be required to acquire and operate several medical facilities in different ways. First, VA would be required to enter into a contract with an appropriate entity for the construction and operation of a nursing home. VA would be responsible for paying all costs of construction and assuring the contractor an 80% occupancy rate. The bill calls for the contract to provide that the contractor operate the VA-owned facility for five years after construction, with provision for renewing the contract for up to five years.

Under section 3, VA would also be required to contract for planning, design, and construction of a second medical facility, which the contractor could then either lease or sell back to the VA. It would be operated by VA using VA employees. In contrast to the requirements regarding other facilities to be obtained under this program, the provision is not specific as to what type of medical facility should be constructed or where it should be located. Finally, the Administrator would be required to acquire two existing

medical facilities, both of which must be located in urban areas. The first such facility must be purchased and must be suitable for furnishing both hospital and nursing home services. The second facility must be leased, but the provision is not specific with respect to the services and level of care it should provide.

The bill also sets funding limitations in section 6 on the implementation of the pilot program. It requires that the Administrator use up to $25 million of the VA's "working reserve funds" available in fiscal year 1986 to purchase an existing medical facility under the pilot program. Section 6 would also require that the President include in the fiscal year 1987 budget request, a statement of the expenditures needed to carry out the entire pilot program mandated by section 3 of the bill, and the proposed appropriations needed to fund the program. Finally, section 6 would mandate that the costs to pay personnel and other operating costs for the two existing facilities must be obtained through savings from reallocation of resources from other VA facilities that have surplus beds, are underutilized, or are converted to perform new missions.

VA opposes the pilot program proposed in sections 3 and 6 of the bill. The premise underlying the proposal for the pilot program would appear to be that VA can acquire new or replacement health care facilities of acceptable quality and sufficient to meet veteran needs more quickly, and at a lower cost than under existing methods. We do not believe the proposed pilot program offers a satisfactory methodology for testing that premise.

The pilot program proposes that VA acquire two facilities by simply contracting with an appropriate entity (we assume a private corporation) to plan, design, and construct the facilities. The notion underlying the bill assumes that if the entire matter were left to the private contractor, the facility would be able to begin operation more quickly and at less cost. We disagree. To ensure appropriate standards and functionality, the VA would have to provide the contractor, as we do now, with information regarding the kind of facility needed, its size, what services it should provide, where it should be located, and what quality standards would have to be met. In short, VA would still have to do the planning necessary to assure that the facility would most efficiently serve the needs of the population which will use it and meet VA standards for health care facility construction. Thus, VA must provide the contractor with detailed specifications and continue to coordinate through all phases of the project. It would be irresponsible to do otherwise. It is

unclear that this process, which is essentially what we do now, would result in any significant savings of time or cost. The VA already contracts with the private sector for the design and construction of our facilities, based on VA standards, specifications and rigorous quality and cost controls throughout the course of such contracts.

One element of the pilot program also proposes that VA simply turn over the care of veterans to a private contractor. The contractor would build the facility to care for veterans, and then would operate it. Such a proposal runs counter to the longstanding congressionally mandated VA mission that eligible veterans be provided care in independent VA-operated health care facilities. It continues to be the policy of the VA that whenever possible, VA provide a complete hospital and medical service in VA-owned and operated facilities.

Specific provisions of section 3 are also very ambiguous, giving rise to major questions. For example, VA is directed in one instance to contract for construction and operation of a nursing home, and contractually, we must guarantee the contractor an 80% veteran occupancy rate. However, the bill does not specify how VA will pay operating costs. Is the contractor free to fill 20% of the beds with nonveterans at a pure profit to itself? Are we to pay a per diem for the veteran patients only? Are we to pay total operating costs including the costs for nonveteran patients? Section 3 also directs VA to contract for planning, design, and construction of a medical facility which the contractor will then lease or sell to the VA. VA now ordinarily contracts for the design and construction of facilities, but we do not lease or purchase them after we paid for construction. Is it intended that this particular facility be constructed on land owned by the contractor necessitating our purchase or lease after we have built it? Are the Davis-Bacon Act and other Federal requirements applicable to that construction?

As regards the pilot program overall, we believe the information which it would produce is unlikely to provide a meaningful basis for determining the most cost-effective means of acquiring medical facilities for VA. Each VA health care facility, be it a medical center, a nursing home, an outpatient clinic, or a domiciliary, is unique. Facilities vary significantly in size, mission, patient makeup, location and capability for delivering various types of services. For example, it would be unreasonable to gauge by the same indices a relatively small unaffiliated facility in a rural area, which provides a great deal of psychiatric care, with a large affiliated urban facility providing a full range of services. All of these

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variables affect the cost of the acquisition and operation of a facility and make it unrealistic to draw meaningful conclusions from the acquisition and operation of four different facilities that must necessarily be tailored to local demographics, the capabilities of other VA and Government facilities in the region, and the strengths and weaknesses of other medical facilities in the community.

We also object to the pilot program because it would direct that VA acquire medical facilities outside of normal planning processes and that contracts for acquisition be entered into by the unrealistically short deadline of January 1, 1987. VA uses a well developed process for determining what the mission of a facility should be, where it should be located, what its size should be, and whether it should be newly built, purchased, leased, or whether existing facilities should simply be enlarged or renovated. Section 3 would require VA to acquire and operate several health care facilities completely outside of this facility planning process.

We strongly believe it would be far more efficient and cost effective to use existing sources of information to estimate the costs of acquiring facilities in different ways than to carry out costly pilot test programs. VA has constructed various types of health care facilities in recent years. We could more easily and reliably compare relative costs if we could obtain accurate and complete cost data from the private sector, and use economic modeling techniques. Unfortunately, VA has been largely unsuccessful in its efforts to obtain cost data from private sector institutions. The General Accounting Office was similarly unsuccessful when it attempted last year to compare the cost of VA nursing homes to private sector nursing homes. Nonetheless, presuming the availability of objective, verified data, the same cost comparison results as intended by the pilot program could be achieved without a massive expenditure of public funds.

In addition to our objections to the pilot program itself, we strongly object to the provisions of section 6 of the bill which sets limits on its implementation. First, we do not believe it would be prudent to reduce the VA's existing working reserve fund by $25 million to acquire a hospital under the pilot program. The fund now contains approximately $27 million, and that amount might be less in fiscal year 1986. In any case, a $2 million remainder after the expenditure of $25 million would be grossly deficient to meet upcoming needs. Even more troublesome is the untested premise that VA can simply "reallocate resources" to provide the considerable monies required to pay the operating costs of facilities acquired under the pilot program. We strongly believe

reallocation of resources among VA facilities should only be accomplished through normal VA planning processes. The funding needs for this pilot program should not dictate the reallocation of resources among VA facilities.

Section 4 would require VA to report on the extent to which it furnishes "respite care" and our plans for furnishing such care in the future. Although the bill does not define the term "respite care," we understand that term to mean institutionalizing chronically ill individuals for brief periods so as to provide family members a respite from the demands of home care. VA has no "respite care" program at this time. In light of the need for a specific statutory basis to establish such a program and our interest in testing the efficacy of furnishing respite care, we have submitted draft legislation to authorize VA to conduct a three-year pilot test for service-connected veterans. Section 4 of S. 1007, however, appears to be premised on the erroneous assumption that VA already has such authority and has developed plans for implementing it. In the absence of a statutory basis for VA to provide respite care, VA cannot provide the kind of definitive information contemplated in section 4. However, this type of information could be included in our proposed pilot test program.

Section 5 of the bill requires that within 90 days after enactment, VA must report to the Congress estimating the cost of increasing the number of community nursing home beds available for use by the VA by 50% and 75% respectively. The report must specify the cost savings likely to result from decreased construction of VA-owned nursing home beds as a result of increasing available community nursing home beds. It must also provide a comparison of the cost per patient day for care in VA-owned and operated nursing homes as opposed to care furnished in other VA facilities, presumably medical centers. Finally, section 5 encourages the Administrator to use contractual authority to provide care to as many veterans as is practicable in community nursing homes located in nonurban areas.

At this time, approximately 33% of VA nursing home care is actually provided in VA facilities, 39% is provided in community nursing homes, and 28% is provided in state homes. Although it is not clear, we assume that section 5 is intended to seek estimates of the costs involved if VA simply increased the percentage of VA patients receiving care in community nursing homes by 50% and 75% respectively. VA can provide cost estimates, but other factors should be considered to determine the feasibility of implementing such an increase, for example, location, supply, etc.

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Currently, the VA provides approximately 12% of all nursing home care now being furnished to the veteran population. More importantly, VA provides only approximately 2% of the nursing home care provided in this country, and only about 39% of that is provided in community nursing homes. Accordingly less than 1%, or less than one nursing home bed in every one hundred is paid for by the VA. Thus, we question the likelihood that VA demand for nursing home care would have any significant impact upon the supply of nursing homes in this country. A private nursing home proprietor is unlikely to build a new nursing home or increase the size of an existing home premised on a small increase in demand by the Veterans' Administration.

It should also be noted that the construction of new nursing home beds is dependent upon states granting certificates of need for additional beds. Currently, very few certificates are being issued in states throughout the country. The VA can exercise no control over this state process. Thus, we do not anticipate that if section 5 were enacted that VA could furnish much helpful data.

If amended as noted above, we would not oppose sections 2, 4, and 5 of the bill. The costs of implementing these sections would not be significant. However, we do oppose sections 3 and 6 of the bill. Costs for the pilot program could be determined only after decisions are made regarding the types of facilities which should be acquired, where they would be located, and what size they would be.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Everett Alvarez Jr.

HARRY N. WALTERS
Administrator

CHANGES IN EXISTING LAW MADE BY S. 876 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

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PART I—GENERAL PROVISIONS

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CHAPTER 1—GENERAL

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§ 101. Definitions

For the purposes of this title—

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(29) The term "Vietnam era" means (*A*) the period beginning *on* August 5, 1964, and ending on May 7, [1975.] *1975, and (B) the period beginning on February 21, 1961, and ending on May 7, 1975, in the case of a veteran who served in the Republic of Vietnam during such period.*

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CHAPTER 3—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

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Subchapter II—Administrator of Veterans' Affairs

§ 210. Appointment and general authority of Administrator; Deputy Administrator

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(b)(1) * * *

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(2)(A) * * *

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(C) For the purposes of this paragraph—

(i) The term "administrative reorganization" means a consolidation, elimination, abolition, or redistribution of functions under the authority granted the Administrator under the second sentence of paragraph (1) of this subsection.

(ii) The term "covered office or facility" means a Veterans' Administration office or facility that is the permanent duty station for 25 or more employees or that is a free-standing outpatient clinic.

(3)(A)(i) The Administrator may not in fiscal year 1986 or any subsequent fiscal year implement a grade reduction described in division (ii) of this subparagraph unless the Administrator first submits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report containing a detailed plan for such reduction and detailed justification for the plan, including a determination by the Administrator, together with data supporting such determination, that, in the personnel area supporting such determination, that, in the personnel area concerned, the Veterans' Administration has a disproportionate number of employees at the salary grade or grades selected for reduction in comparison to the number of such employees at the salary levels involved who perform comparable functions in other departments and agencies of the Federal Government and in non-Federal entities. Any such report shall be submitted not later than the beginning of a period of 90 calendar days (not including any day on which either House of Congress is not in session) prior to the implementation of any proposed grade reduction.

(ii) A grade reduction referred to in division (i) of this subparagraph is a systematic reduction, for the purpose of reducing the average salary cost for Veterans' Administration employees described in division (iii) of this subparagraph, in the number of such Veterans' Administration employees at any specific grade level.

(iii) The employees referred to in division (ii) of this subparagraph include—

(I) health-care personnel who are determined by the Administrator to be providing either direct patient-care services or services incident to direct patient-care services; and

(II) individuals who meet the definition of professional employee as set forth in section 7103(a)(15) of title 5 and are employed in the capacity of engineers or attorneys.

(B) Not later than the forty-fifth day after the Administrator submits a report pursuant to subparagraph (A) of this paragraph, the Comptroller General of the United States shall submit to such Committees on Veterans' Affairs a report on the Administrator's compliance with such subparagraph and shall include in the report the Comptroller General's opinion as to the accuracy of the Administrator's determination (and of the data supporting such determination) made pursuant to such subparagraph.

(C) In the case of Veterans' Administration employees not described in division (iii) of subparagraph (A) of this paragraph, the Administrator may not in any fiscal year implement a systematic reduction for the purpose of reducing the average salary cost for such Veterans' Administration employees that will result in a reduction in the number of such Veterans' Administration employees at any specific grade level at a rate greater than the rate of the reductions

systematically being made in the numbers of employees at such grade level in all other agencies and departments of the Federal Government combined.

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PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

610. Eligibility for hospital, nursing home and domiciliary care.
611. Care during examinations and in emergencies.
612. Eligibility for medical treatment.
612A. Eligibility for readjustment counseling and related mental health services.
612B. Eligibility for counseling for former prisoners of war.
613. Medical care for survivors and dependents of certain veterans.
614. Fitting and training in use of prosthetic appliances; seeing-eye dogs.
615. Tobacco for hospitalized veterans.
616. Hospital care by other agencies of the United States.
617. Invalid lifts and other devices.
618. Therapeutic and rehabilitative activities.
619. Repair or replacement of certain prosthetic and other appliances.
620. Transfers for nursing home care; adult day health care.
620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities[; pilot program].
620B. Community-based psychiatric residential treatment for chronically mentally ill veterans; pilot program.
620C. Noninstitutional alternatives to institutional care; pilot program.

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

621. Power to make rules and regulations.
622. Evidence of inability to defray necessary expenses.
623. Furnishing of clothing.
624. Hospital care, medical services, and nursing home care abroad.
625. [REPEALED.]
626. Reimbursement for loss of personal effects by natural disaster.
627. Persons eligible under prior law.
628. Reimbursement of certain medical expenses.
629. Recovery by the United States of the cost of certain care and services.
630. Community residential care.
630A. Chiropractic services; pilot program.

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Subchapter I—General

§ 601. Definitions

For the purposes of this chapter—

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(8) The term "rehabilitative services" means such professional, counseling, and guidance services and treatment programs (other than those types of vocational rehabilitation services provided under chapter 31 of this title) as are necessary to restore, to the

maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person.

(9) The term "chiropractic services" means the manual manipulation of the spine performed by a chiropractor (who is licensed as such by the State in which he or she performs such services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))) to correct a subluxation of the spine. For the purposes of this paragraph, such term does not include physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded.

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Subchapter II—Hospital, Nursing Home or Domicilliary Care and Medical Treatment

§ 610. Eligibility for hospital, nursing home, and domicilliary care

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(e)(1)(A) * * *

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(3) Hospital and nursing home care and medical services may not be provided under or by virtue of subsection (a)(5) of this section after [the end of the one-year period beginning on the date the Administrator submits to the appropriate committees of Congress the first report required by section 307(b)(2) of the Veterans Health Programs Extension and Improvement Act of 1979 (Public Law 96-151; 93 Stat. 1098).] *September 30, 1989.*

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§ 612A. Eligibility for readjustment counseling and related mental health services.

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(g)(1) During the twelve-month period ending on September 30, 1988, the Administrator shall take appropriate steps to ensure—

(A) the orderly transition, by October 1, 1988, of that part of the program established under this section for the provision of readjustment counseling services by Veterans' Administration personnel from a program providing such services primarily through centers located in facilities situated apart from the health-care facilities operated by the Veterans' Administration for the provision of other health-care services under other provisions of this chapter to a program providing readjustment counseling services primarily through such health-care facilities; and

(B) the continued availability after such date of readjustment counseling and related mental health services under this section to veterans eligible for the provision of such counseling and services who request[ed] such counseling [before such date].

* * * * * * *

(h)(1) In order to evaluate the effectiveness, feasibility, and desirability of providing veterans eligible for readjustment counseling under this section with additional services described in paragraph (2) of this subsection, through facilities furnishing such counseling, the Administrator, during the period beginning January 1, 1986, and ending December 31, 1988, shall conduct a pilot program to provide and coordinate the provision of such additional services.

(2) The additional services referred to in paragraph (1) of this subsection that shall be provided and coordinated under such pilot program are—

(A) counseling with respect to and assistance in applying for all benefits and services under laws administered by the Veterans' Administration for which veterans participating in the pilot program may be eligible;

(B) employment counseling, training, placement, and related services described in sections 2003 and 2003A of this title or provided under any other laws administered by the Secretary of Labor;

(C) initial intake and referral services with respect to alcohol or drug dependence or abuse disabilities and followup services for veterans who have received treatment for such dependence or abuse disabilities; and

(D) coordination assistance for veterans participating in the pilot program with respect to such veterans' receipt of (i) services provided under the pilot program, and (ii) other benefits and services provided under laws administered by the Veterans' Administration, the Secretary of Labor, or any other Federal agency or official.

(3)(A) In order to carry out the pilot program under this subsection, the Administrator shall—

(i) designate as demonstration projects ten facilities which, on the date of the enactment of this section are providing readjustment counseling (which projects shall be referred to as Vietnam Veteran Resource Centers (hereinafter in this subsection referred to as "Centers")),

(ii) provide such additional staff and other resources as are necessary to enable such Centers to provide the services referred to in paragraph (2) (A), (C), and (D) of this subsection, and

(iii) notify the Secretary of Labor of the need for the assignment, pursuant to subparagraph (B)(ii) of this paragraph, of personnel to provide the services described in paragraph (2)(B) of this subsection at such Centers.

(B)(i) The Administrator shall be responsible for coordinating the assignment and use of employees, on full- or part-time bases, as appropriate, in each Center and, shall in carrying out that responsibility, make maximum feasible use of the Veterans' Administration employees who are providing services at each facility onthe date it is designated as a Center under this subsection.

(ii) The Secretary of Labor shall provide for the assignment to each Center, on full- or part-time bases, as appropriate, of disabled veterans' outreach specialists appointed pursuant to section 2003A of this title or employees onthe staffs of local employment services offices who are assigned to perform services pursuant to section 2004 of this title.

(4)(A) In order to ensure appropriate guidance, coordination, implementation, and assessment of the pilot program under this subsection, the Administrator shall establish, and provide appropriate staffing and other resources for, a Vietnam Veteran Resource Center Coordinating Committee (hereinafter in this subsection referred to as the "Committee").

(B) The Committee shall be composed of—

(i) a member or members appointed by and representing the Administrator;

(ii) a member or members appointed by and representing the Chief Medical Director;

(iii) a member or members appointed by and representing the Chief Benefits Director; and

(iv) a member appointed by and representing the Assistant Secretary of Labor for Veterans' Employment.

(C) Not less frequently than every 6 months, the Committee shall report to the Administrator, the Chief Medical Director, the Chief Benefits Director, and the Assistant Secretary of Labor for Veterans' Employment on the implementation and status of the pilot program. The first such report shall be submitted not later than June 30, 1986.

(5) After the Committee is established pursuant to paragraph (4) of this subsection, the Administrator may delegate to the Chief Medical Director the responsibility for carrying out the pilot program.

(6)(A) Not later than April 1, 1987, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience under the pilot program during its first 15 months of operation. The report shall include—

(i) the Administrator's assessment of—

(I) the effectiveness of the pilot program in providing and coordinating the provision of the services described in paragraph (2) of this subsection and counseling and services furnished under subsections (a) and (b) of this section; and

(II) the cost-effectiveness of the program;

(ii) a description of any administrative actions that the Administrator plans to take generally to increase the coordination of the provision of such services to eligible veterans and to other veterans;

(iii) any recommendations for legislation, relating to the provision of such services to eligible veterans and to other veterans, that the Administrator considers appropriate; and

(iv) a comparison of such assessment, plans, and recommendations with the evaluation of and the recommendations relating to the readjustment counseling program included in the report required by subsection (g)(2) of this section.

(B) Not later than April 1, 1989, the Administrator shall submit to such Committees a final report on the program. The report shall include updates of all information provided in the report submitted pursuant to subparagraph (A) of this paragraph, the Administrator's final assessment of the pilot program based on 36 months of operation, and any recommendation for administrative or legislative action that the Administrator considers appropriate to include in the report.

§ 612B. Eligibility for counseling for former prisoners of war

The Administrator may establish a program under which, upon the request of a veteran who is a former prisoner of war, the Administrator may, within the limits of Veterans' Administration facilities, furnish counseling to such veteran to assist such veteran in overcoming the psychological effects of such veteran's detention or internment as a prisoner of war.

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§ 618. Therapeutic and rehabilitation activities

(a) * * *

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(f) Neither a veteran's participation in an activity carried out under this section nor a veteran's receipt of remuneration as a result of such participation may be considered as a basis for the denial or discontinuance of a rating of total disability for purposes of compensation or pension based on the veteran's inability to secure or follow a substantially gainful occupation as a result of disability.

(g) Notwithstanding any other provision of law, no amount of remuneration provided to an individual as a participant in a therapeutic or rehabilitative activity carried out pursuant to this section shall be included in determining annual income for purposes of pension payments.

* * * * * * *

§ 620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities[; pilot program]

(a)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may conduct a **[**pilot**]** program under which the Administrator may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. Such **[**pilot**]** program shall be planned, designed, and conducted by the Chief Medical Director, with the approval of the Administrator, so as to demonstrate any medical advantages and cost effectiveness that may result from furnishing such care and services to veterans with such disabilities in contract facilities as authorized by this section, rather than in facilities over which the Administrator has direct jurisdiction.

* * * * * * *

(e) The Administrator may not furnish care and treatment and rehabilitative services under subsection (a) of this section after the last day of the **[**fifth**]** *eighth* fiscal year following the fiscal year in which the **[**pilot**]** program authorized by such subsection is initiated.

[(f) Not later than March 31, 1984, the Administrator shall report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the findings and recommendations of

the Administrator pertaining to the operation through September 30, 1984, of the pilot program authorized by this section.]

(f)(1) The Administrator shall monitor the performance of each contract facility furnishing care and services under the program carried out under subsection (a) of this section to determine—

(A) with respect to the program, the medical advantages and cost-effectiveness that result from furnishing such care and services;

(B) with respect to the contract facilities generally—

(i) the level of success under the program, considering—

(I) the rate of successful rehabilitation for veterans furnished care and services under the program;

(II) the rate of readmission to contract facilities under the program or to Veterans' Administration health-care facilities by such veterans with respect to disabilities referred to in subsection (a) of this section;

(III) whether the care and services furnished under the program obviated the need of such veterans for hospitalization for such disabilities;

(IV) the average duration of the care and services furnished such veterans under the program;

(V) the ability of the program to aid in the transition of such veterans back into their communities; and

(VI) any other factors that the Administrator considers appropriate;

(ii) the total cost for the care and services furnished by each contract facility under the program;

(iii) the average cost per veteran for the care and services furnished under the program; and

(iv) the appropriateness of such costs, by comparison to—

(I) the average charges for the same types of care and services furnished generally by other comparable halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities; and

(II) the historical costs for such care and services for the period of time that the program carried out under subsection (a) of this section was a pilot program, taking into account economic inflation.

(2) Not later than February 1, 1988, the Administrator shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience under the program during the preceding 4 fiscal years, including, but not limited to (A) a description of the care and services furnished, (B) the matters referred to in paragraph (1) of this subsection, and (C) the Administrator's findings, assessment, and recommendations regarding the program conducted under this section.

(g) The authority of the Administrator to enter into contracts under this section shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

§ 620B. Community-based psychiatric residential treatment for chronically mentally ill veterans; pilot program

(a)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may, during the period beginning January 1, 1986, and ending December 31, 1989, conduct a pilot program under which the Administrator may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities (hereinafter in the section referred to as "contract facilities") for eligible veterans suffering from chronic mental illness diabilities. Such pilot program shall be planned, designed, and conducted by the Chief Medical Director, with the approval of the Administrator, so as to demonstrate (A) any medical advantages and cost-effectiveness that may result from furnishing such care and services to veterans with such disabilities in such contract facilities rather than in inpatient facilities over which the Administrator has direct jurisdiction, and (B) the potential, as a result of the furnishing of such care and services, for enabling such veterans to live in settings other than inpatient facilities.

(2) Before furnishing such care and services to any veteran through a contract facility, the Administrator shall approve (in accordance with criteria which the Administrator shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which such veteran is to be furnished such care and services.

(b) In the case of each eligible veteran provided care and services under this section, the Administrator shall designate a Veterans' Administration employee to provide case management services.

(c) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a contract facility under this section. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the contract facility. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Veterans' Administration facility that provided the assistance.

(d) For the purposes of this section—

(1) The term "eligible veteran" means a veteran who at the time of referral to a contract facility—

(i) is being furnished hospital, domiciliary, or nursing home care from the Veterans' Administration for a service-connected chronic mental illness disability, or

(ii) is being furnished such care from the Veterans' Administration for a chronic mental illness disability and is a veteran described in section 612(f)(2) of this title.

(2) The term "case management" includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration), monitoring, reassessment, and followup.

(e)(1) Not later than February 1, 1989, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the experience under the pilot program during the first 36 months of the program. The report shall include the Administrator's interim evaluation and findings regarding—

(A) the quality of care furnished to participating veterans through contract facilities;

(B) the effectiveness of the pilot program in enabling the participating veterans to live outside of Veterans' Administration inpatient facilities and to achieve independence in living and functioning in their communities; and

(C) the effect of the pilot program on the average daily census in the Veterans' Administration hospitals, nursing homes, and domiciliary facilities participating in the program (taking into account whether the beds previously occupied by the participating veterans were subsequently occupied by other eligible veterans or remained unoccupied).

(2) Not later than April 1, 1990, the Administrator shall submit to such Committees a final report on the pilot program. The report shall include updates of all information provided in the interim report submitted pursuant to paragraph (1) of this subsection, the Administrator's final evaluation, findings, and conclusions regarding the program based on 48 months of operation, and any recommendations from administrative or legislative action that the Administrator considers appropriate to include in such report.

§ 620C. Noninstitutional alternatives to institutional care; pilot programs

(a)(1) In order to evaluate the effectiveness, feasibility, and desirability of various actions that would obviate the need for furnishing hospital, nursing home, or domiciliary care to veterans eligible under this chapter for and otherwise in need of such care, the Administrator, during the period beginning January 1, 1986, and ending December 31, 1989, and subject to subsection (c) of this section, shall conduct a pilot program under which such veterans will be furnished at ten demonstration project sites medical, rehabilitative, and health-related services in noninstitutional settings. Not less than five of such projects shall involve the use of a geriatric evaluation unit at a Veterans' Administration health-care facility.

(2) In selecting veterans for participation in the program, the Administrator shall accord priority to veterans who have service-connected disabilities, to veterans who are 65 years of age or older, and to veterans who are totally and permanently disabled.

(b)(1)(A) In order to avoid duplication of services available from the Veterans' Administration and other sources to veterans partici-

pating in the pilot program and to avoid fragmentation of effort under the program, the Administrator shall in the conduct of the program (i) furnish appropriate health-related services solely through contracts with appropriate public and private agencies that provide such services, and (ii) in the case of each veteran furnished services under the program, appoint a Veterens' Administration employee to furnish case management services.

(B) For the purposes of subparagraph (A) of this paragraph, "case management" includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration), monitoring, reassessment, and followup.

(2) In order further to avoid such duplication and fragmentation and in order to evaluate the cost-effectiveness of utilizing certain health services of agencies other than the Veterans' Administration in cases in which no Veterans' Administration facility in the vicinity of a domonstration project provides such services, the Administrator, in not more than two of the projects, may utilize appropriate health services of appropriate public and private agencies that furnish such services.

(3) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a facility furnishing services to veterans under paragraph (1)(A) of this subsection. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the facility concerned. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Veterans' Administration facility that provided the assistance.

(c)(1) The total cost of conducting the pilot program under this section shall not exceed 60 percent of the cost that would have been incurred by the Veterans' Administration during the period of the pilot program if the veterans being furnished services under the pilot program had been furnished, instead, nursing home care under section 610 fo this title. In any one fiscal year, the cost of carrying out the pilot program shall not exceed 65 percent of the cost that would have been so incurred for such year under such section 610.

(2) Expenditures for services furnished to veterans under the pilot program shall be made from appropriated funds that would otherwise have been expended to provide intermediate hospital care to eligible veterans.

(d)(1) The Administrator shall conduct a study of the pilot program to determine with respect to the participating veterans—

(A) the feasibility, medical advantages, and cost-effectiveness of the services furnished under the program as an alternative to hospital, nursing home, or domiciliary care; and

(B) the extent to which such a program can—

(i) furnish such veterans with more appropriate kinds and levels of care than they would otherwise receive;

(ii) reduce hospital, nursing home, or domiciliary facility admission rates for such veterans;

(iii) reduce the number of days that such veterans are institutionalized;

(iv) reduce mortality rates among such veterans; and

(v) reduce the cost of long-term care for such veterans under this chapter.

(2) Not later than February 1, 1989, the Administrator shall submit to the Committee on Veterans' Affairs of the Senate and the House of Representatives an interim report on the study required by paragraph (1) of this subsection setting forth the Administrator's findings based on the results of the study of the program's first 36 months experience. The report shall include a description of the administration of the program (including a description of the veterans furnished services and of the services furnished under the pilot program), the Administrator's interim evaluation of and findings on the program (including the matters referred to in paragraph (1) of this subsection), and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

(3) Not later than April 1, 1990, the Administrator shall submit to such Committees a final report on the study required by paragraph (1) of this subsection. The report shall include updates of all information provided in the interim report submitted pursuant to paragraph (2) of this subsection, the Administrator's final evaluation, findings, and conclusions regarding the program based on 48 months of operation (in the context of an assessment, which the report shall contain, of the needs of older eligible veterans for non-institutional health and health-related services and of the availability of such services from non-Veterans' Administration sources), and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

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Subchapter III—Miscellanous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

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§ 630. Community residential care

(a)(1) * * *

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(f) For the purpose of this section, the term "community residential-care facility" means a facility that provides room and board and such limited personal care for and supervision of residents as the Administrator determines, in accordance with regulations pre-

scribed under this section, are necessary for the health, safety, and welfare of residents.

§ 630A. Chiropractic services; pilot program

(a) The Administrator, subject to the provisions of this section, shall conduct a pilot program consisting of not less than one demonstration project in each of five geographic regions of the United States during the period beginning January 1, 1986, and ending December 31, 1988—

(1) to furnish certain chiropractic services to veterans eligible for medical services under this chapter; and

(2) to evaluate the therapeutic benefits and the cost-effectiveness of furnishing such chiropractic services to such veterans.

In developing the pilot program, the Administrator shall consult with the Secretary of Defense regarding the demonstration projects carried out by the Secretary under section 632(b) of the Department of Defense Authorization Act, 1985 (10 U.S.C. 1092 note).

(b)(1) The Administrator shall, subject to subsection (c) of this section and under regulations which the Administrator shall prescribe, reimburse a veteran eligible for medical services under this chapter for the reasonable charge for chiropractic services furnished to the veteran under the demonstration projects carried out under subsection (a) of this section, for which such veteran has made payment, if—

(A) such chiropractic services were for the treatment of a service-connected neuromusculoskeletal condition of the spine,

(B) the veteran is a veteran who has been furnished hospital care by the Veterans' Administration for a neuromusculoskeletal condition of the spine within a 12-month period prior to the furnishing of such chiropractic services, or

(C) the veteran is a veteran described in section 612(f)(2) of this title who has been furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine,

to the extent that such veteran is not entitled to such chiropractic services or reimbursement for the expenses of such services under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.

(2) The Administrator may, in lieu of reimbursing a veteran for a reasonable charge for chiropractic services under paragraph (1) of this subsection, make payment of the reasonable charge for such chiropractic services directly to the chiropractor who furnished such services.

(c)(1) The Administrator shall, in consultation with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, establish a schedule of reasonable charges for chiropractic services furnished under the demonstration projects carried out under subsection (a) of this section. Such schedule shall be consistent with the reasonable charges allowed under section 1842 of the Social Security Act (42 U.S.C. 1395u).

(2) The amount payable by the Administrator for chiropractic services furnished under such demonstration projects shall not exceed $600 in any 12-month period in the case of any veteran.

(d)(1) Notwithstanding any other provision of this title, total expenditures for chiropractic services reimbursed under this section shall not exceed $2,000,000 in any fiscal year.

(2) Expenditures for such services shall be made from appropriations that would otherwise have been expended for travel and incidental expenses under section 111 of this title.

(e) Not later than April 1 of each of the years 1987, 1988, and 1989, the Administrator shall prepare and submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an annual report on the pilot program carried out under this section during the preceding fiscal year. Each such report shall include for such fiscal year—

(1) the number of requests made by eligible veterans for reimbursement or payment for chiropratic services under this section and the number of such veterans who made such requests;

(2) the number of such reimbursements or payments made and the number of veterans to or from whom such reimbursements or payments were made; and

(3) the total amount of the expenditures for such reimbursements and payments.

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PART IV—GENERAL ADMINISTRATIVE PROVISIONS

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CHAPTER 57—RECORDS AND INVESTIGATIONS

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Subchapter I—Records

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§ 3305. Confidentiality of medical quality-assurance records

(a) Records and documents created by the Veterans' Administration as part of a medical quality-assurance program, *other than reports submitted pursuant to section 4152 of this title,* are confidential and privileged and may not be disclosed to any person or entity except as provided in subsection (b) of this section.

(b)(1) Subject to paragraph (2) of this subsection, a record or document described in subsection (a) of this section shall, upon request, be disclosed as follows:

(A) To a Federal agency or private organization, if such record or document is needed by such agency or organization to perform licensing or accreditation functions related to Veterans' Administration health-care facilities or to perform monitoring, required by statute, of Veterans' Administration health-care facilities.

(B) To a Federal executive agency or provider of health-care services, if such record or document is required by such agency or provider for participation by the Veterans' Administration in a health-care program with such agency or provider.

(C) To a criminal or civil law enforcement governmental agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or document be provided for a purpose authorized by law.

(D) To health-care personnel, to the extent necessary to meet a medical emergency affecting the health or safety of any individual.

(2) The name of and other identifying information regarding any individual Veterans' Administration patient or employee, or any other individual associated with the Veterans' Administration for purposes of a medical quality-assurance program, contained in a record or document described in subsection (a) of this section shall be deleted from any record or document before any disclosure made under this subsection if disclosure of such name and identifying information would constitute a clearly unwarranted invasion of personal privacy.

(3) No person or entity to whom a record or document has been disclosed under this subsection shall make further disclosure of such record or document except for a purpose provided in this subsection.

(4) Nothing in this section shall be construed as authority to withhold any record or document from a committee of either House of Congress or any joint committee of Congress, if such record or document pertains to any matter within the jurisdiction of such committee or joint committee.

(5) Nothing in this section shall be construed as limiting the use of records and documents described in subsection (a) of this section within the Veterans' Administration (including contractors and consultants of the Veterans' Administration).

(6) Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of statistical information regarding Veterans' Administration health-care programs (including information on aggregate morbidity and mortality rates associated with specific activities at individual Veterans' Administration health-care facilities) that does not implicitly or explicitly identify individual Veterans' Administration patients or employees, or individuals who participated in the conduct of a medical quality-assurance review.

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PART V—BOARDS AND DEPARTMENTS

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CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

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SUBCHAPTER IV—VETERANS' ADMINISTRATION HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM

4141. Establishment of program; purpose; duration.
4142. Eligibility; application; written contract.
4143. Obligated service.
4144. Breach of contract; liability; waiver.
4145. Exemption of scholarship payments from taxation.
4146. Program subject to availability of appropriations.

SUBCHAPTER V—QUALITY ASSURANCE

4151. Responsibilities for quality assurance.
4152. Reports.

Subchapter I—Organization; General

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§ 4110. Disciplinary boards

(a) * * *

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(e) The Administrator, within such limitations as he may prescribe may delegate to the Chief Medical Director the authority vested in him by subsections (b) and (d) of this section to (1) appoint the chairman and secretary of a disciplinary board, such official to have the power prescribed by this section, and (2) receive and act upon the recommendations of such a board. Any person against whom disciplinary action is taken under authority delegated pursuant to this subsection shall have the right to appeal such action to the Administrator, but in the absence of such an appeal the decision of the Chief Medical Director shall have the same force and effect as a decision of the Administrator.

(f) This section applies in any case in which a reduction or revocation of the clinical privileges of any person employed in a position described in paragraph (1) of section 4104 of this title is proposed by reason of a charge of inaptitude, inefficiency, or misconduct. A disciplinary board may recommend and the Administrator may impose a reduction or revocation of clinical privileges only (1) in a case in which, prior to the hearing under this section, such person has been provided with notice of the proposal to reduce or revoke such privileges, and (2) on the basis of deficiency in such person's clinical practice.

(g) Nothing in this section shall limit the Administrator's authority to protect the health and safety of veterans by temporarily reassigning an employee for the purpose of suspending the employee's exercise of clinical privileges, or for the purpose of otherwise restricting the employee's clinical activities, pending the outcome of a proceeding under this section.

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Subchapter IV—Veterans' Administration Health Professional Scholarship Programs

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§ 4146. Program subject to availability of appropriations

The authority of the Administrator to make payments under this subchapter is effective for any fiscal year only to the extent that appropriated funds are available for such purposes.

Subchapter V—Quality Assurance

§ 4151. Responsibilities for quality assurance

(a) The Administrator shall—

(1) establish and conduct a comprehensive quality-assurance program to monitor and evaluate the quality of health care furnished by the Department of Medicine and Surgery;

(2) delineate the responsibilities of the Department of Medicine and Surgery with respect to the conduct of the Veterans' Administration quality-assurance program; and

(3) allocate sufficient resources, and sufficient personnel with the necessary skills and qualifications, to enable the Department of Medicine and Surgery to carry out such delineated quality-assurance responsibilities.

(b) The Inspector General of the Veterans' Administration shall allocate sufficient resources, and sufficient personnel with the necessary skills and qualifications, to enable the Inspector General to monitor the quality-assurance program conducted by the Department of Medicine and Surgery.

(c) The Administrator shall, as part of the comprehensive quality-assurance program established and conducted pursuant to subsection (a)(1) of this section, require the Chief Medical Director—

(1) in consultation with the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Armed Forces and other appropriate professional bodies, to establish and maintain a compilation of prevailing national mortality and morbidity standards for each type of surgical procedure conducted by the Department of Medicine and Surgery;

(2)(A) to collect data on mortality and morbidity rates of each surgical procedure, conducted by the Department of Medicine and Surgery; and

(B) to compile such data for inclusion in the report to be submitted pursuant to section 4152 of this title (i) for each cardiac surgery, heart transplant, and renal transplant program, and (ii) in the aggregate, for each other such surgical procedure;

(3) to—

(A) compare the data so compiled to the standards compiled pursuant to clause (1) of this subsection,

(B) make an analysis of the relationship between such data and the (i) characteristics of the patient population, (ii) the level of risk for the procedure involved, based on patient age, the type and severity of the disease, the effect of any complicating diseases, and the degree of difficulty of the procedure, and (iii) any other factors that the Chief Medical Director considers appropriate,

(C) evaluate such data in light of the factors described in divisions (i) through (iii) of subclause (B) of this clause in order to determine whether there are any significant devi-

ations from the standards that would indicate deficiencies in the quality of care, and

(D) explain any such deviations; and

(4) to make any recommendations based on data compiled and the comparisons, analyses, evaluations, and explanations made pursuant to clause (3) of this subsection.

§ 4152. Reports.

(a) Not later that January 1 of 1987, 1989, and 1991, the Chief Medical Director shall submit a report to the Administrator on the experience through the end of the prior fiscal year under the quality-assurance program carried out pursuant to section 4151(a) of this title. Each such report shall include the data compiled and the comparisons, analyses, evaluations, and explanations made pursuant to subsection (c)(3) of section 4151 of this title with respect to the period covered by such report and any recommendations made pursuant to subsection (c)(4) of such section. Not later than 60 days after receiving each such report, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a copy of the report, together with any comments concerning the report that the Administrator considers appropriate.

(b) A report submitted pursuant to subsection (a) of this section shall not be considered a record or document as described in section 3305(a) of this title.

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

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Subchapter I—Acquisition and Operation of Medical Facilities

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§ 5002. Acquisition of medical facilities

(a) The Administrator shall provide medical facilities for veterans entitled to hospital, nursing home, or domiciliary care or medical services under this title.

(b) No medical facility may be constructed or otherwise acquired or altered except in accordance with the provisions of this subchapter.

(c) In carrying out this subchapter, the Administrator—

(1) shall provide for the construction and acquisition of medical facilities in a manner that results in the equitable distribution of such facilities throughout the United States, taking into consideration the comparative urgency of the need for the services to be provided in the case of each particular facility; and

(2) shall give due consideration to excellence of architecture and design.

(d)(1) In connection with the assessment of the health care needs of veterans in a particular area for the purpose of planning how best to meet such needs, the Administrator shall develop criteria for determining whether to proceed with planning for the construction or acquisition of a new or replacement medical facility and, if it is determined to proceed, for choosing among the alternatives of constructing the facility, leasing an existing medical facility that satisfies the requirements of paragraph (3) of this subsection, or purchasing an existing medical facility that satisfies such requirements.

(2) After January 1, 1986, the Administrator shall not proceed to develop preliminary plans for a new or replacement medical facility except in accordance with the criteria established under paragraph (1) of this sub ection and after considering the option of leasing or purchasing an existing facility that satisfies the requirements of paragraph (3) of this subsection.

(3) A facility satisfies the requirements of this paragraph if—

(A) the facility is available, or will be available in timely fashion in the foreseeable future, for purchase or lease;

(B) the facility meets the current and projected needs and specifications of the Veterans' Administration for furnishing health care to eligible veterans residing within a 100-mile radius of where the new or replacement facility is planned to be located, or is adaptable to meet such needs and specifications;

(C) the facility can be acquired at an estimated cost (including the costs of any necessary adaptation) that does not exceed the estimated cost of construction of a medical facility to meet such needs and specifications; and

(D) the estimated cost of operating the facility (after adaptation, if necessary) does not exceed the estimated cost of operating a medical facility that would otherwise be constructed.

* * * * * * *

§ 5004. Congressional approval of certain medical facility acquisitions

(a) In order to ensure the equitable distribution of medical facilities throughout the United States, taking into consideration the comparative urgency of the need for services to be provided in the case of each particular facility—

(1) no appropriation may be made for the construction, alteration, or acquisition (not including exchanges) of any medical facility which involves a total expenditure of more than $2,000,000 [unless each committee has first adopted a resolution approving such construction, alteration, or acquisition and setting forth the estimated cost thereof; and] *except as authorized by a law based on legislation reported from the committees setting forth the amount that may be appropriated and expended for such construction, alteration, or acquisition;*

(2) no funds may be expended to construct, remodel, extend, or acquire, or develop preliminary plans (except to the extent necessary to develop project requirements) for, a medical facility for the furnishing of hospital care if the construction, remodeling, extension, or acquisition involves a total expenditure of more than $20,000,000, except as authorized by a law based on legislation reported from the committees;

(3) no new or replacement medical facility shall be constructed or acquired within excess of 700 hospital beds and no project that involves a total expenditure of more than $20,000,000 for remodeling or extending a medical facility for the furnishing of hospital care shall be undertaken if upon completion of such project the number of hospital beds at the facility would exceed 700; and

[(2)] *(4)* no appropriation may be made for the lease of any space for use as a medical facility at an average annual rental of more than $500,000 unless each committee has first adopted a resolution approving such lease and setting forth the estimated cost thereof.

(b) In the event that the President or the Administrator proposes to the Congress the funding of any construction, alteration, lease, or other acquisition to which subsection (a) of this section is applicable, the Administrator shall submit to each committee, on the same day, a prospectus of the proposed medical facility. Such prospectus shall include—

(1) a detailed description of the medical facility to be constructed, altered, leased, or otherwise acquired under this subchapter, including a description of the location of such facility and, in the case of a prospectus *proposing* the construction of a new or replacement medical facility, a description of the consideration that was given, pursuant to criteria established under section 5002(d) of this title, to acquiring an existing facility by lease or purchase;

(2) an estimate of the cost to the United States of the construction, alteration, lease, or other acquisition of such facility (including site costs, if applicable); and

(3) an estimate of the cost to the United States of the equipment required for the operation of such facility.

(c) The [estimated cost of] *contract price for* any construction, alteration, lease, or other acquisition that is approved [under this section, as set forth in the pertinent] *by a law or* resolutions described in subsection (a) of this section [may be increased by the Administrator in the contract for such construction, alteration, lease, or other acquisition by an amount equal to the percentage increase, if any, as determined by the Administrator, in construction, alteration, lease, or other acquisition costs, as the case may be, from the date of such approval to the date of contract, but in no event may the amount of such increase exceed 10 per centum of such estimated cost] *may exceed the amount set forth pursuant to such subsection in the pertinent provisions of such law or resolutions by an amount determined by multiplying such amount by the lesser of (1) the percent, if any, as determined by the Administrator, by which construction, alteration, lease, or other acquisition costs, as the case may be, increased from the date of such approval to the date of contract, or (2) 10 percent.*

(d) In the case of any medical facility approved [for construction, alteration, lease, or other acquisition by each committee under subsection (a) of this section] *by each committee under subsection (a) of this section for lease* for which funds have not been appropriated within one year after the date of such approval, either such committee may by resolution rescind its approval at any time thereafter before such funds are appropriated.

(e) In any case in which the Administrator proposes that funds be used for a purpose other than the purpose for which such funds were appropriated, the Administrator shall promptly notify each committee, in writing, of the particulars involved and the reasons why such funds were not used for the purpose for which appropriated.

(f) The Administrator may accept gifts or donations for any of the purposes of this subchapter.

§ 5004A. Hospital facility planning

(a) In order to ensure that decisions regarding the need for and size of each proposed new or replacement Veterans' Administration medical facility for the furnishing of hospital care are made taking into account appropriate statutory eligibility and priorities for health care from the Veterans' Administration, the Administrator of Veterans' Affairs and the Comptroller General of the United States, after consultation with the Assistant Secretary of Defense for Health Affairs, veterans' service organizations, and representatives of the private hospital industry, shall jointly develop and submit to the appropriate committees of the Congress a methodology for determining the appropriate types of hospital beds and the appropriate numbers of each type of hospital bed to be provided for in each proposed project for the construction of new or replacement facilities for the furnishing of hospital care by the Veterans' Administration.

(b) The methodology developed pursuant to subsection (a) of this section shall take into account (1) the projected need for health care of veterans residing in the geographic area to be served by the proposed health-care facility who have service-connected disabilities and veterans residing in such areas who meet the income criteria for the receipt of pension under chapter 15 of this title, and (2) any

recent or planned changes in treatment modalities for the furnishing of inpatient and outpatient care which might affect the demand for inpatient bed capacity.

(c)(1) Not later than October 1, 1986, the Administrator and the Comptroller General shall submit to the appropriate committees of the Congress a joint report on the methodology developed pursuant to subsection (a) of this section.

(2) Not later than October 1, 1987, the Administrator and the Comptroller General shall submit to such committees a joint report on the implementation of such methodology.

(3) The Comptroller General shall submit to such committees such further reports as the Comptroller General considers appropriate regarding the implementation of such methodology or regarding the need to revise such methodology.

(d) No funds may be expended after April 1, 1987, for the development of preliminary plans for a facility described in subsection (a) of this section unless the types of beds and number of each type to be provided in such facility are based on the methodology developed pursuant to subsection (a) of this section.

APPENDIX

This appendix consists of the Committee's May 24, 1984, resolution approving VA medical facility construction projects for which fiscal year 1985 funding had been proposed, the letter of transmittal to the Majority Leader of the Senate (an identical transmittal letter was sent to the Speaker of the House of Representatives), and a statement of Committee Views regarding the resolution. The listing of approved projects that was attached to the resolution is deleted.

ALAN K. SIMPSON, WYO., CHAIRMAN
STROM THURMOND, S.C.
ROBERT T. STAFFORD, VT.
FRANK H. MURKOWSKI, ALASKA
ARLEN SPECTER, PA.
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RUDY BOSCHWITZ, MINN.
ALAN CRANSTON, CALIF.
JENNINGS RANDOLPH, W. VA.
SPARK M. MATSUNAGA, HAWAII
DENNIS DECONCINI, ARIZ.
GEORGE J. MITCHELL, MAINE

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

May 24, 1984

Honorable Howard Baker
Majority Leader
The United States Senate
Washington, D.C. 20510

Dear Mr. Majority Leader:

Pursuant to section 5004(a) of title 38, United States Code, the Senate Committee on Veterans' Affairs has adopted the enclosed resolution by a poll of its members completed today, May 24 , 1984. The resolution approves 55 Veterans' Administration medical facility construction projects, working drawings for three projects, and one medical facility lease. In the listing attached to the resolution and incorporated by reference therein, the projects are identified and their estimated costs and, as to seven replacement/ modernization projects, maximum bedsizes are indicated.

With the exception of the five FY 1985 Administration-proposed replacement/modernization projects, the Committee, in approving Administration-proposed projects, has approved them at the proposed size and Administration cost estimate. However, the Committee has reallocated the total resources for the five replacement/modernization projects in a way that is more equitable and responsive to statutory priorities for care for service-connected-disabled veterans. The result is that the Committee resolution reduces the bedsizes and estimated costs for each of those five projects and, within the overall level of the total estimated costs for them ($784 million), approves two additional projects, one in Philadelphia and one in Baltimore. In the case of each replacement or replacement/modernization project, the Committee notes that its approval is for a facility to replace the existing facility. (Enclosed with the resolution is a statement of Committee Views regarding this reallocation).

The Committee has acted favorably on the VA's request for Committee approval for working drawings for two projects in fiscal year 1985 (Durham, North Carolina, and Knoxville, Tennessee) and one project in fiscal year 1984 (Tampa, Florida). However, the Committee also believes that, under the authority provided in section 211 of Public Law 98-233, this Committee's approval would not be required if "working reserve" funds in the VA's major construction account were used for the working-drawing phase for these projects.

With warm regards,

Sincerely,

ALAN K. SIMPSON
Chairman

ALAN CRANSTON
Ranking Minority Member

Enclosures

CC: Honorable Mark O. Hatfield
Honorable John C. Stennis
Honorable Jack Garn
Honorable Walter D. Huddleston
Honorable Harry N. Walters

ALAN K. SIMPSON, WYO., CHAIRMAN
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United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, D.C. 20510

RESOLUTION OF THE COMMITTEE ON VETERANS' AFFAIRS

United States Senate

RESOLVED BY THE COMMITTEE ON VETERANS' AFFAIRS OF THE UNITED STATES SENATE, pursuant to section 5004(a) of title 38, United States Code, that the major medical construction projects specified in the attached listing are approved at the fiscal year 1985 estimated costs, bedsizes, and total estimated costs shown.

ALAN K. SIMPSON
Chairman

ALAN CRANSTON
Ranking Minority Member

Adopted: May 24, 1984

Senate Committee on Veterans' Affairs
Views on Approval of
FY 1985 VA Replacement/Modernization
Construction Projects

After reviewing agency responses to Committee requests for information about and explanations of the assumptions, processes, and justifications for the array of medical facility construction projects for which the Veterans' Administration requests funding each year, the Committee continues to be very concerned about current policies used for determining the need for and size of the facilities proposed for construction. Essentially, the VA bases its planning on the demographics of the entire veteran population in the area to be served. However, it does not take into account relative statutory priorities, especially as they relate to the needs of veterans with service-connected disabilties.

In light of the large potential demand for care from service-connected-disabled and other priority groups within the fast-growing population of older veterans, it is essential that the implications of current practice be evaluated. Present decisions regarding allocations of medical-facility construction dollars represent not only very large expenditures in the near term ($1.4 billion in total estimated costs for projects proposed for at least partial funding in FY 1985) but will also have a marked influence on the VA's capacity to provide care over the next two to three decades.

In its review of the Administration's proposals for five replacement/modernization projects, the Committee was concerned about the rationale for inclusion and exclusion of particular projects in the replacement/modernization category. After analysis of information and testimony received by the Committee, no clear priority determinations or planning criteria and goals were discernible which would explain the inclusion of the five projects and the exclusion of two projects, in Philadelphia and Baltimore (which the VA had included in its submission to the Office of Management and Budget), in establishing the VA's budget request for FY 1985. Thus, the Committee, in adding two replacement/modernization proposals, has structured its approvals in a way that would reflect the Committee's and the Congress' long-standing emphasis on ensuring a comprehensive hospital system for service-connected disabled veterans and the Committee's interest in developing an approach that would permit scarce resources to be distributed so as to provide for more equitable access by veterans to better quality health care.

To achieve this result, the Committee devised a model for reallocating the aggregate level of the VA's FY 1985 appropriations requests for replacement/modernization projects ($78 million), the total estimated costs for these projects ($784 million), and

the approximate total of the hospital bed levels proposed for these projects (3384 beds). The model (described in detail below) that the Committee developed emphasizes the statutory priority to be accorded to veterans receiving care for service-connected disabilities.

Description of Model:

The model developed to achieve an improved allocation of funding and hospital bed numbers for replacement/modernization projects uses (1) VA hospital census data (agencywide and for the existing seven facilities) showing the percentages of hospitalized veterans who are service-connected disabled veterans receiving care for their service-connected disabilities (SCSC) or for non-service-connected disabilities (SCNSC) and those who are in receipt of VA need-based pension (PEN), (2) VA hospital occupancy-rate data, and (3) the Administration-proposed number of hospital beds for each new facility (the nursing home beds proposed in four of the projects were excluded from the calculations). These data were then given various weights and incorporated into a model to determine approved hospital bedsizes. Service-connected disabled veterans receiving care for a service-connected disability were accorded twice the weight of service-connected disabled veterans receiving care for a non-service-connected disability. Together, these service-connected categories were accorded twice the weight of veterans receiving care who were in receipt of VA pension benefits (used as a measure of the care provided to eligible needy veterans). The resulting calculation for each facility was then adjusted by the agency-wide calculation of these factors and multiplied by the Administration-proposed bedsize. Finally, that product was adjusted to take into account the relative intensity of utilization as shown in occupancy rates for the existing facilities. This final calculation produced the bedsize approved by the Committee as the maximum bedsize for the proposed project.

The following is a mathematical description of the model:

$$\left(\frac{2(2 \times SCSC_i + 1 \times SCNSC_i) + 1 \times PEN_i}{2(2 \times SCSC_j + 1 \times SCNSC_j) + 1 \times PEN_j} \times \text{Administration-proposed bedsize}_i \right) \times \frac{OR_i}{OR_k} = \text{Approved bedsize}_i$$

OR = occupancy rate
i = individual facility
j = VA agencywide
k = average of 7 facilities

Values for SCSC, SCNSC, PEN, OR, and Administration-proposed bedsizes for each project are shown in the attached chart.

HOSPITAL BEDSIZING DATA

Facility	Percentage SC SC	Percentage SCNSC	Percentage PEN	Percentage Neither SC nor PEN	Occupancy Rate (%)	No. of existing beds	VA-proposed bedsize/est. cost ***	Committee-approved hospital bedsize/est. cost ***
Allen Park	15.4	14.6	19.4	49.4	73.3	539	521/ $232	451/ $184.4
Augusta	31.0	9.3	20.7	39.0	84.4	722	630/ $102.4	630/ $94
Houston	8.4	12.4	22.9	56.2	85.4	1,018	919/ $286	685/ $195.6
Mountain Home	8.1	11.6	31.3	49.0	78.3	510	530/ $70.3	387/ $47.1
New York	8.2	17.5	26.2	48.0	81.6	1,030	784/ $93.3	646/ $70.6
Philadelphia	12.5	3.0	23.9	60.6	80.0	479	(538/ $147.6)*	369/ $103.3
Baltimore	7.1	7.1	24.0	61.8	80.1	291	(400/ $119.8)*	325/ $88.8
VA-Wide	16.1	13.8	23.8	45.9	79.2	---	---	---
					TOTALS:	4,627	3,384/ $784 (4,322/ $1,051.4)**	3,493/ $783.8

* Not proposed in FY 85 budget; bedsize and dollar amount included in VA draft prospectus provided to Committee.
** Includes projects not proposed in FY 85 budget.
*** In millions of dollars.

ASSUMPTIONS:
(1) Minimum hospital size is 325 (affects Baltimore).
(2) Maximum hospital size is that presently proposed by VA (affects Augusta).
(3) Nursing home care beds subtracted from calculations (affects Allen Park (120), Augusta (120), Houston (120), and Philadelphia (120)).